Analytical Music Therapy

Edited by
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Jessica Kingsley Publishers
London and Philadelphia

First published in the United Kingdom in 2002
by Jessica Kingsley Publishers Ltd
116 Pentonville Road
London N1 9JB, England
and
29 West 35th Street, 10th fl.
New York, NY 10001-2299, USA

www.jkp.com

Library of Congress Cataloging in Publication Data
A CIP catalog record for this book is available from the Library of Congress

British Library Cataloguing in Publication Data
A CIP catalogue record for this book is available from the British Library

ISBN 1 84310 058 4

Printed and Bound in Great Britain by
Athenaeum Press, Gateshead, Tyne and Wear

for Mary Priestley

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Part 3

Preface

This book is an offspring of basic ideas from one of the central debates of the Ninth World Congress of Music Therapy (Washington 1999), entitled *The Special Track on Five International Models of Music Therapy,* which was divided thus:

- Analytical Music Therapy – Mary Priestley and Johannes Th. Eschen;
- Behavioral Music Therapy – Clifford Madsen;
- Benenzon Music Therapy – Rolando Benenzon;
- Guided Imagery and Music – Helen Bonny;
- Nordoff-Robbins Music Therapy – Clive Robbins.

This track – devised by Kenneth Aigen (International Scientific Committee Chair) and coordinated by Dr Kenneth E. Bruscia – brought together so many important lecturers in different fields within Analytical Music Therapy, that I suggested collecting and revising these lectures, and then publishing them, in order to deepen the understanding of:

- how Analytical Music Therapy (AMT) came into being;
- what AMT is (theory) and can do (practice).

We also hope to inspire different views:

- on some of its facets;
- on adjoining fields (for example, psychodynamic movement);
- and on AMT training.

As in other disciplines, we find in AMT different ideals and practices, especially in the core of AMT training, for example, *Lehrmusiktherapie*, 'Self-Experience for Music Therapy Students', 'Experiential Training in Music Therapy', and so on.

We hope this book will mirror these differences and will enhance future dialogues and further developments.

Johannes Th.Eschen

Part One

CHAPTER I

Analytical Music Therapy – Origin and Development

Mary Priestley and Johannes Th. Eschen

The following is a transcript of a lecture given at the Ninth World Congress of Music Therapy (Washington 1999).

Johannes Th. Eschen:

Mary Priestley is the founder of Analytical Music Therapy, and we are grateful to have today parts of a 'Mary lecture', written down especially for this congress (Priestley 1998). Benedikte will read Mary's paragraphs and I will add some thoughts concerning German developments, defining features, etc.

Mary Priestley:

In this little talk I will refer to the client or patient as 'she' and the music therapist as 'he' for simplification. You are free to interpret this in any way you like. Here are some thoughts about Analytical Music Therapy that I would like to share.

Analytical Music Therapy was born out of psychoanalysis, but it is very different from psychoanalysis. It came into being together with my own ten-year Kleinian analysis which started in 1968, the same year as my Guildhall Music Therapy training. It then developed in 98 sessions of 'Intertherapy' with Peter Wright and Marjorie Wardle. We each took it in turns to be client and therapist one to another, experimenting with techniques and ideas, before we used them on our hospital patients and, in my case, also with private clients. This in turn gave birth to my book Music Therapy in Action which came out in 1975 (Priestley 1975).

JE:

For some years – before going into music therapy – I had had in Germany an analysis on Freudian lines. In my Guildhall Music Therapy training (1972–73) my first practical was with Mary Priestley. When I heard of her 'Intertherapy', I asked her to introduce me to it through self-experience sessions. With another Guildhall student, we each took turns to be client and therapist, and she was our supervisor.

So we had the privilege to be her very first AMT students. Later on I could transfer AMT to Germany – developing special forms of AMT training.

In the following years Mary also introduced experienced music therapists or music therapy students, mainly German and international colleagues, for example Benedikte Scheiby.

MP:

In analysis the only reality is in the verbal transference and countertransference relationship in the ongoing present. All the positive and negative feelings of the analysed are directed toward the analyst. In Analytical Music Therapy usually less negative feelings are directed toward the therapist as their improvised duet music or sound expression allows for guilt-free expressions of anger, envy or hatred. This sound duet also allows the turning of violent expression into deeper layers of feeling such as sadness, disappointment or even love. In the playback listening, the client often hears the holding and responsive sound expression of the therapist for the first time, and she realises that he was there for her throughout the violence and into the peaceful ending.

JE:

The AMT improvisation induces an altered state of mind, a 'tertiary thinking process' as Ammon would call it (Ammon 1974, p.54). Dream-like thinking or (following Freud) 'primary process thinking…ignores the categories of space and time…and images tend to become fused and can readily replace and symbolize one another. Secondary process thinking obeys the laws of grammar and formal logic…and is governed by the reality principle' (Rycroft 1972, p.124). In our upbringing we are normally taught to draw a strict line between dream and reality.

'Real' is called only what is outside and can be seen by others; our dreams and fantasies however are called 'non-real', although they are also an inner

reality for our psyche. Thinking in creative processes is (following Ammon) conceivable as 'tertiary process thinking':

- it can be dared in a 'facilitating environment';
- then the ego boundaries are more or less open – open to the partner and open to our un- or preconscious, to our emotions;
- this can lead to flowing contacts between memory and reality, to a new and wider ego-organisation, to new integration.

MP:

Psychoanalysis is carried out 'in abstinence' and frustration of action to express loving feelings, but in Analytical Music Therapy there is often deep satisfaction and closeness in the sound duet. The therapist, of course, sticks to the exploration of the client's life and feelings, but he is far from being the Freudian mirror in the sound duet. There is a difference between our verbal relationship and our musical relationship. In the music, or sound expression as I will call it, we are closer and more open about our response to the client's feelings. Together we are creating something that has never been there before, and together we listen to the playback. Then we break apart in discussing our creation, the client finding words to further express the sound duet. We part as separate beings. The only situation like this that I can think of in daily life would be the dual relationship of a couple in love, with their creative carnal relationship and their everyday verbal interaction.

One client asked me if the therapeutic aspect is in the music or the words. I answered, 'in both'. The words lead us to an area to be explored, so we can set a title for the improvisation which again leads to more words, as normal communication is carried on in words. We move from one dimension to another. Sometimes it is difficult for the client to turn the sound expression into words. She is perhaps not ready to own these feelings consciously. Never mind. We can wait until she is ready to claim them. However, I have never had any trouble with my clients or my hospital patients in turning from words to music. But I don't talk about 'music' but say to her 'make sounds to let me know what you are feeling'. The word 'music' often conjures up humiliating scenes from school days of being turned out of the choir for being tone-deaf or a growler, or being rapped over the knuckles by an unhelpful piano teacher for playing a wrong note.

When we are improvising on an imaginative visualization, I feel like an adult holding up a friend who can then see what is happening on the other side

of a high wall, and let me know what she feels about it without me knowing what is happening. The work is very intense and there is a feeling that we two are somehow in the centre of the world, wherever the session is.

JE:

AMT is non-directive.

The opening improvisation of each session has the function of establishing or re-establishing contact between patient and therapist, and of giving her the opportunity to become aware of her feelings, reminiscences, and problems. In the following dialogue these feelings and thoughts may be verbalized and sometimes she may include experiences or dreams of the last days. Following this, we decide together how to go on.

AMT improvisations, day-dream improvisations – or, as I call them, associative improvisations – quite often reveal massive difficulties and problems. In the following dialogue she gets distance and perspective by sharing. When we aim at giving her the opportunity to find her own solutions (normally, mine are not very helpful for her), it is mostly indicated that the problem material should be returned back to the same layer of psyche whence it was aroused, following up with an improvisation in the security of the facilitating therapy environment. Again and again it is fascinating how originally and imaginatively the 'dream psyche' creates for seemingly hopeless situations new and surprising personally adequate solutions.

MP:

The music therapist has the opportunity to let his countertransference feelings direct his music. Starting with concordant identification, which I call e-countertransference, I take the lead from the client, making it safe for her to be herself with any sound expression she may make. But, if the client is in the paranoid-schizoid position of Kleinian thought, she may, by projective identification, project into me certain strong emotions, while only expressing delicate or feeble sounds herself. If I realise this, I have the choice of carefully keeping these strong feelings out of our duet, or boldly expressing them hoping she will be seduced into expressing and exploring them with me and finding it safe to do so. If I don't realise what is going on and express the strong feelings in unawareness, then it is an enactment or complementary identification and I may only realize this when we hear the playback.

JE:

In associative improvisations normally the ego boundaries are relatively open, and strong emotions might be aroused. This is not the best state of mind to leave a session in. So the last improvisation quite often has to be centred on facts of the musical material, thus with musical means helping back to 'secondary process thinking' – back to reality.

MP:

It is good that there are different schools of music therapy for working with various client disabilities and diseases. There are now music therapists working with almost every kind of disability, and also working with successfully functioning people who just want to explore feelings about a difficult relationship, or focus on a special area of unease. An occasion like this conference is a splendid chance to get to know other systems of music therapy, so that referrals can be made to colleagues if we think their approach is more suitable for certain clients who come to us for assessment.

It is essential that each music therapist should get to know his strengths and weaknesses and seek work that will make the best use of his talents. It doesn't suit every music therapist to work full-time in this role. One may feel better doing part-time teaching or performing. Another may feel more at home working at writing, talks or videos, and demonstrations of music therapy.

Finally, I like to say to young music therapists that you yourselves are your most important patient. You must find a leisure-time lifestyle that balances with the pressure and emotionality of the therapy work, with something for the body to counteract all the sitting, and something for the mind to sweep away all the tension and pain.

And don't be too proud to ask a collegue for a few sessions of Analytical Music Therapy to work through a difficult situation yourself if the need arises.

JE:

Consequently I introduced in Germany, as an important part of AMT training – as we call it *Lehr-Musiktherapie* – our own 'training music therapy' (comparable to the analysis training of the psychoanalyst):

- self-experience in group music therapy;
- individual music therapy;
- and in the last part of the studies, Intertherapy.

So I, the student, can understand from within 'what AMT can do':

- in this 'facilitating environment' I can easily go into my day-dreams, realize, without too much anxiety, that I have new openness to my partner, to my un- or preconscious, to my emotions;
- and how this can lead to new contacts between memory and reality, to a new and wider ego-organisation, to new integration and flexibility.

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CHAPTER 2

Analytical Music Therapy – Introduction

Johannes Th.Eschen

The following is a transcript of a lecture given at the Ninth Congress of Music Therapy (Washington 1999).

Before I started to outline this lecture, I visited Mary Priestley, the founder of Analytical Music Therapy in London. She gave me a lecture, written down especially for this congress (Priestley 1998), and Benedikte read parts of it yesterday in my lecture Origin and Development.

Thinking processes

To understand what is going on in AMT it might be helpful to consider thinking processes first. Ammon has given a simple overview of different modes of thinking:

> Dream-like thinking or (following Freud) 'primary process thinking… displays *condensation* and *displacement*, i.e. images tend to become fused and can readily replace and symbolize one another…ignores the categories of space and time… Secondary process thinking obeys the law of grammar and formal logic…and is governed by the reality principle. (Rycroft 1972, p.124)

In our upbringing we are normally taught to draw a strict line between dream and reality.

We call 'real' only that which is outside and can be seen by others; our dreams and fantasies however are called 'non real', although they are also a very important inner reality for our psyche. Thinking in creative processes is (following Ammon 1974) conceivable as 'tertiary process thinking', a state of mind where we can easily oscillate between primary and secondary process thinking:

- it can be dared in a 'facilitating environment';
- then the ego boundaries are more or less open, open to the partner and open to our un- or preconscious, to our emotions;
- this can lead to flowing contacts between memory and reality, to a new and wider ego-organisation, to new integration.

AMT improvisation can normally create such a 'facilitating environment',

- where the ego boundaries are more or less open – open to the partner and to the ongoing music, open to our un- or preconscious, to our emotions;
- this can lead to flowing contacts between memory and reality, to a new and wider ego-organisation, to new integration.

Before I come to some case examples I have to say some words about the following key concepts to help understand AMT: empathy, countertransference, lehrmusiktherapie and 'focusing music therapy'.

Empathy

Empathy is 'the power of projecting one's personality into (and so fully understanding) the object of contemplation' (The Concise Oxford Dictionary 1972).

'The concept implies that one is both:

- feeling oneself into the object and;
- remaining aware of one's own identity as another person'.

(Rycroft 1972, p.42)

In AMT, empathy is one of the preconditions for understanding. Having been understood (by mother, father, therapist, and so on) is one of the preconditions to understanding oneself and developing self-esteem and sense of identity.

Experiencing the empathy of the training therapist fosters the empathetic potentials of the therapy trainee/student.

Countertransference

There are two kinds of countertransference – one bad and one good:

1. The bad countertransference: When the analyst is transferring or incorporating experiences from his former relationships into his current relationship with a patient. In this sense,

'countertransference' is a disturbing, distorting element in treatment' (Rycroft 1972, p.42).

2. The good and helpful countertransference: The therapist may have pictorial and physical perceptions, thus 'resonating' with un- or preconscious emotions of the patient.

Freud had said: 'Es ist bemerkenswert, daß das Unbewußte eines Menschen mit Umgehung des Bewußte auf das Unbewußte eines anderen reagieren kann.' (It is remarkable that the unconscious of one person can, bypassing the conscious, react directly to the unconscious of another person.) (Freud 1975, p.153)

In many cases a patient who is not yet able to tolerate the mirroring of emotions (delegated to the therapist) through words can accept the mirroring through music, and this quite often gives easier access to repressed memories and feelings. (Priestley 1975)

Supervision can help the therapist:

- to discriminate own material and countertransference material;
- to lessen the strain, if he fails to discriminate the materials;
- to understand the material and problems of the patient in correlation to his own problems (and vice versa).

Lehrmusiktherapie (Training music therapy)

The function of *Lehrmusiktherapie* is manifold:

1. In group and individual music therapy the student can learn by experiencing his own personality alterations, developments, and so on, and by understanding personally from within what music therapy can do.
2. Positive experiences with music therapy enhance and foster insight: therapy for therapists is needed. Patients can normally only develop as long as the therapist is willing and able to do so.
3. Intertherapy (Priestley 1975) is an excellent tool (as a nonhierarchic music therapy for music therapists) for the psychohygiene of music therapists.
4. Supervision and supervising over and over again provide new possibilities to assess and revise critically and continually our music therapy methods.

The sequence of *Lehrmusiktherapie* can consist of: group music therapy (throughout the whole study time); individual music therapy; and (after some terms of individual music therapy) Intertherapy.
Intertherapy can be organized in two forms:

1. The teaching therapist is always the supervisor and two students change roles as patient and therapist. The disadvantage of this construction seems to be:

   a) Transferences are sometimes mingled and therefore it is more difficult to understand them.
   b) Sometimes the patient does not dare to 'burden' the therapist, because he in turn will be the therapist for his fellow student.

2. a) First phase: The teaching therapist is the supervisor. Student A is therapist for student B, B for C and C for A.

   b) Second phase: Students also take the function of the supervisor. If needed, the teaching therapist can act as a co-supervisor. The students change their roles (as in the 'classical intertherapy-circle' of Mary Priestley):

	Therapist	***Patient***	***Supervisor***
Session 1:	A	B	C
Session 2:	C	A	B
Session 3:	B	C	A
Session 4:	A	B	C

etc.

Every student has his therapist, his patient and his supervisor and in regularly changing they experience all three roles.

Focusing music therapy

- The music therapist can help the patient to focus his/her attention and to intensify it by offering special materials and/or rules.
- I made observations in music therapy situations and realized that when a person has musical instruments and other people together in a room there are normally the following sequential steps:
  - eye contact with instruments and/or partners;
  - experimenting with one or more instruments;
  - contact through instrument(s) with a partner (calling, answering, and so on) and/or with the music (playing motifs, melodies, harmonies, and so on).
- It is mainly as a result of the behaviour of the therapist, if verbal contacts develop. He can allow this to continue or intervene through rules, suggestions or simply musically.
- By formulation of rules, and so on, the therapist can, if appropriate, direct the attention to:
  - instruments, tone materials, forms, motifs, and so on;
  - communication with partners (by means of mirroring, answering, and so on);
  - musical or transmusical associations. They can surface if attention to musical *gestalt* or communication with partners is reduced and daydreams are encouraged.

Concentration on tertiary process thinking can be dared only when the situation is reasonably safe and material, partners, and so on, more or less familiar. Only then can we allow our thoughts to oscillate between dream and reality, imagination and observation, shaping of music and spontaneity.

- If the freely fleeting 'back and forth' is producing too much anxiety, the therapist can refocus the patient's attention to more concrete elements of the music and thus create a new 'structural security'. (See Wils 1977 pp.72–80)
- The therapist should never focus the attention too directively. Therefore steering – at least of short phases – has to be given as early as possible to the patient/group.

- Many patients/students can only develop creative processes after having experienced therapeutic situations in which self-control is possible, allowed but not demanded.
- In contrast to traumatic childhood experiences patients/students need new inspiring experiences:
  - I can do something.
  - Someone is listening and responding empathetically.
  - My feelings are respected and answered.
- Frequently such positive creative music therapy situations induce a quick transfer to routine life situations.
- The ability to focus attention on 'what really matters' is growing in an interchange with the awareness and realization of personal value and self-concept.

Now I will add some basic questions and suggest some preliminary answers:

What is AMT?

AMT is an analytically oriented approach to active music therapy. Therapists and patients improvise together and try after that – using techniques of psychoanalysis – to understand what they have done or what had come into their minds when they were improvising. As in many forms of psychoanalysis the dream is seen as *via regia* to our subconscious. Some ways to understand the message of a dream or daydream or an improvisation are:

- to speak out 'free associations' – often they reveal a lot;
- and to observe what's going on in the field of transference and countertransference.

With whom is AMT used?

As you will hear in some of the other AMT lectures, AMT is used with patients in psychiatry, in wide fields of psychosomatic medicine, and in some other areas of the health services.

I would like to add that as the techniques of AMT can free creative potential, they also can be used in management training courses.

What are the goals of AMT?

The goals of AMT are manifold:

1. Instead of the 'labelling approach' of static diagnoses, normally we understand AMT diagnosis as an ongoing process, clarifying the diagnostic knowledge step by step within the therapy.
2. The daydreams and their analyses help the patient to understand underlying problems of their illness, addiction, and so on.
3. This strengthens the inborn self-healing capacities.
4. The freeing of creative potential is a valuable precondition for developing good new contacts in family and society.
5. AMT can help the patient to understand herself more and more and to feel understood by the therapist. This can open her eyes to new horizons, and give her the curiosity and strength to take up new challenges in her life.

How does the therapist work?

The therapist works in improvisations as an experienced partner, answering in the appropriate way as needed:

- sometimes childlike, sometimes on the adult level;
- like a playfellow or accompanist;
- fighting or soothing;
- often supporting and deepening.

Sometimes he has:

- to cry with the crying;
- to laugh with the laughing;
- but in any case, to respect what comes from the patient.

This includes the therapist's deep openness to processes or materials of transference and countertransference.

In the verbal parts of AMT he follows the same basic rules. If possible he is quick of hearing and full of empathy. (There are more details in other parts of this chapter.) Especially in the verbal parts of AMT the therapist is like a midwife – to wait for *kairos*, the very right moment for just this patient to gain

insight, inner freedom, courage and ability, to master new developments and life.

The pathfinder in AMT is not the therapist. If AMT is working successfully, the psyche of the patient finds her very own way. Also, I think a good therapist tries to find the right first moment, when the patient is stable enough, for her to make her own decisions and to end therapy.

What is the nature of the relationship?

The nature of the relationship in AMT has to be adapted to the actual needs of the patient:

- mostly warm and holding – always respecting the patient;
- but, when needed, open and clear, face to face.

The relationship is always deeply influenced by transference or counter-transference. The subconscious contacts between patient and therapist create, quite often, a solid basis for understanding and mutual esteem.

Further basic methodological principles and clinical applications

AMT is non-directive.

The opening improvisation of each session has the function of establishing or re-establishing contact between patient and therapist, and of giving her the opportunity to become aware of her feelings, reminiscences and problems. In the following dialogue these feelings and thoughts may be verbalized and sometimes she may include experiences or dreams of the last days. Following this, we decide together how to go on.

Associative improvisation (aI)

In 'descriptive improvisation' the improvisors follow a predetermined plan. In aI however we have a 'daydream improvisation', in which only the starting situation or emotion is agreed upon. The aI is then free and open for surfacing images and surprising musical or non-musical memories. The improvisors are following their free associations or their emptiness, their nebulous ideas, or clear-cut film-like images.

If an aI is interrupted it is usually because of sudden difficulties. Normally the hindrance, a plastic expression of an anxiety or something like that, provides an excellent new starting point for the next aI, a 'follow-up improvisation'.

After an aI the improvisators try to verbalize important experiences during the aI. This can enhance connections between primary and secondary process thinking, and can make daydreams and their content more obtainable for consciousness and memory. The 'working through' should be done in the same 'language', 'medium', 'context' and so on, for example in a follow-up improvisation. Thus the patient is given a means of developing a genuine solution, his creative dream-solution, much as our psyche is working every night.

The therapist should not solve the patient's problems. His solutions are not the very hope for the patient. The therapist however is collecting the signs of hope and strengthening the patient's trust in his own healing potentials.

The presence of the therapist (or the group) can facilitate coming to grips with 'problem themes', with less anxiety, blockage or inundation.

The forms of experiencing aI are similar to the processes we sometimes use while falling asleep: quick oscillating changes from dream to reality; ignoring the categories of space and time. One aI for example started with:

- actual anger;
- changed to (forbidden!) childhood sadness = a long, deeply sad, delicate music;
- and ended (surprisingly enough) with a musical 'reality rehearsal' for future dialogues.

'Splitting' (Priestley 1975), when two sides of an ambivalence are given to two improvisation partners, is an excellent tool for working through ambivalences:

Person One is improvising, for example, 'fearing extraterrestrial forces'.

Person Two: 'I am an extraterrestrial force'.

One: 'I don't dare to start'.

Two: 'I enjoy starting'.

One: 'I fear to fall'.

Two: 'I fall, but I know it's good to let myself fall'.

After one 'splitting' there has to be, if needed, a second 'splitting', with change of role. But behind the 'real' or 'unreal' anxieties there can be repressed memories, emerging in aI, which can clear up the 'pre-history' of a fear, traumatic roots, and so on. Forbidden anger can show up in an aI and 'rage' – petrified sadness – can melt in 'musical tears', can be thought and felt through, and can be heard back from the tape and reiterated in words.

The 'borders' between aI and material-oriented improvisation (moI) are shiftable. For a patient fearing chaos, a three-part moI 'ordered – unordered – ordered' (with clearly determined material for the ordered parts) might be helpful. Within the security of the safe frame, she can dare a bit of chaos. And if in the chaotic parts 'dreams may come', she herself can limit them, by going back to the ordered part. When mastery of the safe material is lessening the anxieties, more can be dared, played, lived through – maybe one day curiosity towards adventure arises and takes the patient through positive, thrilling new experiences.

Sometimes the therapist can take responsibility for musical order (as a superego representative) and the patient can delve into the unknown. Or the patient is steering by a chorus, signalling when he wants the security of the well-known, or when he wants to explore threatening images. There are many possibilities to organize cyclic changes between moI and aI, according to the patient's needs.

For some patients, having had psychotic or drug dreams, aI is extremely worthwhile. Having gone freely into their drug dream (or psychosis), they had not been able, even if they wanted (horror trip, and so on), to come back to reality. For them it can be of the utmost importance to have, in aI, intense daydreams and feelings, but – in the mode of tertiary process thinking – to experience easy switches from dream back to reality, to the reality of music. For example, now I play, I play the drum, now he plays the cymbal, and so on, and I can go back into the daydream again.

So that you can better understand what I am trying to say, I will now give you an example of group music therapy:

> In an aI we had improvised under the heading 'valley', suddenly one of the patients stopped playing and the group also stopped – as if he had given an understandable signal. In the following verbal 'report' he said: 'My valley became more and more narrow and suddenly there was a steep wall. So I had to stop.' The group agreed to start the next improvisation at that point: 'My valley is becoming more and more narrow; suddenly there is a steep wall.'
>
> After a short starting phase, one patient began to beat sharp tones on his metallophone, and then again higher and again and again higher and higher; but suddenly he changed to soft gliding tones on a glockenspiel, and soon the group finished. He said: 'When I saw the steep wall, I felt at first helpless; but then I took a hammer and beat climbing-irons into the

wall, one after another; and finally I had to change to the soft glockenspiel sounds – I saw a meadow with lots of wonderful flowers.'

A female patient said: 'when he started his ugly metal tones, I felt I had to follow him; and I did so – in spite of some rock-fall. And when he changed to the glock, I knew he had found his way, so I can also find my way.' Another patient said: 'When we started to play, I saw the rut of the trucks, carrying out the stones; I followed the rut easily, and found my way out with ease.'

Afterwards in our ward meeting one of the therapists said: 'The patient talking about the rut will be released in the next few days'.

Some more thoughts on aI (Eschen 1983)

When a patient knows music therapy is going on, she can be free of the pressure – 'I must daydream today' – and relax and wait and see if dreams may come, or tolerate tension today, which tends to induce important material. Like other dreams the aI dreams are normally determined manifoldly. Every glimpse of understanding should be taken up carefully, but nevertheless, 'working through' and 'follow-up' should be used again and again, to reveal new layers of connections. As you know, musical themes (a melody, a sequence of harmonies, a timbre) can stand for specific life situations or feelings. A melody can introduce what its words say. Or a sudden stop in a melody-quote can reveal what determines the omission. Or a chorus can bind together several aIs, thus disclosing working methods of our psyche.

Sequences of aIs enable patients to work through complicated, nearly unsolvable problems step by step.

Dream scenes, such as 'lying down and falling asleep', are, in some therapies, clear signs: 'Enough for today!', 'Follow up next session!', and so on. In other situations a lullaby for the sleeper is urgently needed.

Free associations to aI materials can further understanding. Sometimes an analysis of a problem-solving strategy in a daydream is most helpful. Associations of the therapist (or of group members) can supply important clarifying additions. Associative improvisations quite often reveal massive difficulties and problems. Again, it is fascinating how originally and imaginatively the dream psyche creates, for seemingly hopeless situations, new and surprising

personally adequate solutions as you have heard in my first group music therapy example.

In aI normally the ego boundaries are relatively open, and strong emotions might be aroused. This is not the best state of mind in which to leave a session. So the last improvisation quite often has to be centred on facts of the musical material, thus with musical means helping back to secondary process thinking – back to reality. Therefore the construction of a therapy hour can be, for example:

- entrance improvisation;
- verbal exchange;
- associative improvisation to the first theme;
- verbal exchange;
- follow-up improvisation;
- verbal exchange;
- perhaps a second follow-up improvisation;
- verbal exchange;
- closing improvisation.

Beziehungs-rondo (Relationship-rondo)

For group music therapy sessions I had developed a specialized rondo-form: *Beziehungs-Rondo*, which translated means something like 'Relationship-rondo'.

My groups ideally had six members, five patients and the therapist, and we were sitting in a circle. Normally we began the session improvising in the sequence:

Tutti – duet 1+2 – tutti – duet 3+4 –
tutti – duet 5+6 – tutti.

In the tutti, when all group members improvise together, everyone can try out her instrument (and 'herself today') in the facilitating environment of the group sounds. After that it is often easier to go into a dialogue and to experience: I am noticed and I can dare to play 'question–answer', I can give or take up signals, can accompany or lead and, if it has to be, fight my way ruthlessly – or suddenly switch to sounds of empathy. In such a 'connections-rondo' everyone can speak musically or keep significantly silent.

The rondo is followed by a round, where everyone can say what has been important for him or her, normally in a ritualised sequence, so that each group member has his or her place – even, if needed, allowing for: 'I don't want to say anything!' – possibly an important signal for the group.

If the duets are improvised crosswise (tutti – duet 1+4 – tutti – duet 2+5 – tutti – duet 3+6) the experiences quite often differ widely and confrontations are much easier. In some situations it might be necessary to give clear structure to the tuttis, perhaps by an underlying rhythm. Then a group member or the therapist (as guardian of the rhythm) may help the group to come back securely to the rhythm they had agreed upon.

If in an experienced group (for example students), where only a few members are in the session, it can bring up very deep emotions if the normal rule is altered to: tutti – dialogue with myself – tutti. Another free variation – tutti – two – tutti – two – tutti, and so on – helps group members to become aware of 'when do I want to join?', or 'with whom?', or 'with whom not?' This leads quite often to unintentional (or maybe not unintentional) trios, which reactivate dramatic complicated situations with siblings or other bad triangular problems. As in other exceptional moments the group mostly breaks the 'form', allowing for thoughtful silence or narration.

Case Study

1. Individual music therapy

In a group improvisation a female patient stopped her playing when she had reached a point of hopeless entanglement. As, for once, we did not have enough time for her in the group setting, I suggested she work it through individually and she consented.

The entrance-improvisation started with a short give and take (partner-orientated) and then it became a very harmonic pleasant 'piece' (composition-centred). After that she apologized to me, saying that it had been so beautiful and had nothing to do with her problems. I invigorated her hope that she could express, here and now, whatever she felt important. Then she suggested an improvisation 'entanglement'. After the improvisation she said:

> Mm, I have seen, how I have seen, how everything was entangled; everything chained, hands and feet. Then I was in a hole, and then began the struggle, to cope with the chains, to free myself. Then I

> flew into a passion against myself, and tried to break all these chains, and there was sometimes a beginning, a weak point here, at the high notes. But then I felt the chains down here were only drawn more tightly.
>
> Then I tried with my last power and had the feeling you were fighting with me. But then I got clarity: no one else can bring me out, you yourself must come out.
>
> And then I realized, my strength was fading away, followed by a kind of resignation. I had found somehow a certain kind of rest; rest is not the right word, something like indifference.

Together we thought: what now? I expressed my idea, which had come to me when she was relating her daydream: cocoon. And I asked if she could dare to go deeply into her entanglement in a follow-up improvisation, 'Entanglement', which we later called 'In the cocoon'.

After that she said:

> First this cocoon was forming itself, growing tighter, and then it became very firm, it hardened more and more and so I had to play these tone repetitions, to reflect this tightness and hardness, until it was totally closed. And then there was a bang, and then a yellow butterfly emerged, which was a bit frightened and giddy. It was mixed up, not yet finding its way in the world, trying this and that and here and there until it finally came to something ordered.
>
> Then it could really enjoy itself and its new freedom. Then the view went back to the cocoon, which was hanging there lifelessly – wood tones, to illustrate the lifelessness, hanging on a silk-thread; finally the thread broke, the cocoon fell down and so it was away.

As I knew her, I suggested not to put the butterfly under pressure, and we made a closing improvisation, where it was allowed to fly around dizzily. After that she said: 'It flew from blossom to blossom.'

2. Material-oriented improvisation

Some weeks later in a difficult situation she asked for an improvisation 'ordered – unordered – ordered', and wanted the ordered parts in the

dorian mode, circling around the D. Obviously the direction of attention changed between 'composition-oriented' and 'partner-centred'. Some days later she told me that the following night she had gone, full of suicidal anxiety, to the music therapy room, had repeated the improvisational technique she had experienced with me, and realized with deep relief: 'I can master it, I'm master of myself, I am mistress of myself'. Encouraged she went back to her room and slept deeply and soundly.

Today she is working in her profession as a teacher, with good contact with her pupils, their parents, colleagues and her husband, and cooperating in a self-help group of former patients.

Melody-quotation in music therapy improvisation

Before I come to my conclusion, I add some personal experiences:

In a composition from my time as a church–musician, the melody of *Komm Gott Schöpfer, Heiliger Geist (Veni creator spiritus)* was a symbol for new spirit, new beginnings. In many therapy situations this melody quotation appeared in my improvising, often before I had consciously perceived the turning point, the signs of a new beginning.

In a group therapy, teaching therapy with students, I had the nearly paralysing feeling, 'It's stuck'. Then I incorporated unconsciously in my improvisation a melody, and I remembered its text:

> Das Silber, durch's Feu'r siebenmal bewährt, wird lauter funden; an Gottes Wort man warten soll desgleichen alle Stunden.(The silver, melted by fire seven times, can be found pure; with God's word you likewise shall wait all hours).

This strengthened my patience, to wait for *kairos*, for the right moment.

In an individual therapy a patient worked through her problems for weeks with associative improvisations. Every session, when the last of her daydreams ended, she lay down and started to sleep – a clear signal from her dream-psyche: 'enough for today'. I observed that sometimes before she ended, there would appear 'accidentally' in my improvisation a lullaby. Then I knew at once before she mentioned it that she, without regard for the time, had reached the end of her daydream sequence.

I had a student group improvising – the daydream was to be in an underground cave where there was vaguely a frightening animal. Days later I found myself in the same cave. That day I could easily dance a 'cave-waltz' with the animal, and very much enjoyed playing with it for a while.

Again some days later it helped me, with its fire-breath, to melt precious metals out of the cave walls and to bring valuables into new shapes. In the next session there appeared again a melody, but I had to stop: why? Again I remembered the text 'The silver, melted by… ' I realized that here the fire-breath of my animal would destroy something. I then cautiously 'chiselled' out the cave wall, purposefully beating on the metallophon. Reflecting I understood: in the theory lessons we had spoken of therapy techniques, where the 'stability of the fifth' played an important role. Here my musical brainwave had started – with melody-quotation and the idea of the fifth as 'stable'. But, it can be melted. For example, C/G by 'enharmonic exchange' to B-sharp/G, the two leading notes to the fourth C-sharp/F-sharp. This is comparable to the half-life of diamonds. In daily life we think of diamonds as being stable, but physics is teaching us that even their structure is time-bound. The beauty of diamonds and the stability of the fifth only exist until the time of persevering is over and the time for change and transformation has come.

Conclusion

After having waited patiently for the right moment *(kairos)* we are full of awe and wonder when a psyche is creating a really great dream or an improvisation with incredible depth and clarity.

The power and delicacy of the 'signs of hope' are striking for us, induced by the inborn healing capacity even of very ill patients. Humble respect for the unique potentials of 'just this patient', 'just her psyche with her personal biography' is growing from therapy to therapy. Patients, students and therapists are again and again amazed and fascinated by the works of art, the compositions they have created in aI.

Even musicians with a long fruitful experience of a creative life admire the unconscious inner capacities of creation, quite often miles ahead of their conscious possibilities and enjoy the sparkling richness and vivid intensity of the music, the strength and delicacy of feelings, the clarity of forms and musical developments in associative improvisations.

This was for me a beloved, special field, full of rich and impressive experiences within Analytical Music Therapy.

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CHAPTER 3

Theoretical Bases of Analytical Music Therapy[1]

Susan Hadley

In this chapter I will delineate the theoretical premises underlying Analytical Music Therapy based on my analysis of the original writings of Mary Priestley (1975, 1994). I will also describe ways in which Priestley's original approach has been further developed in unique ways by music therapy clinicians, educators, and researchers.

The clinical theory of Analytical Music Therapy, as developed by Mary Priestley, is based primarily on psychoanalytic concepts of Freud, Jung and Klein. These concepts will be discussed in terms of their intrapersonal (dealing with inner parts of the person/self), interpersonal (relationships with others) and transpersonal (extending beyond or transcending the personal) significance to health or wellness and pathology. The dynamics of the therapeutic relationship, such as transference, countertransference, resistance and the working alliance will then be discussed. Finally, I will discuss the treatment procedures Priestley developed using these concepts.

Intrapersonal concepts

Priestley's understanding of the self is shaped by the Freudian structural model consisting of the 'moral' superego, the 'thinking' ego, and the 'instinctual' id (Bruscia 1987, pp.113–115; Priestley 1994, pp.155–161). A person is believed to be healthy when these aspects of the personality are well-balanced and, thus, the person can function satisfactorily. Pathology is implied whenever one of these aspects of the personality overwhelms the others, that is, if the superego dominates the ego and the id, or if the id is not kept in check by the superego.

Furthermore, these personality structures operate within layers of the self: the conscious, the pre-conscious and the unconscious (Priestley 1994, p.155). Priestley believes that the content of the unconscious influences people without their knowledge and can have detrimental effects. Therefore, in order to live a more satisfactory existence, the unconscious must be brought into consciousness, giving a person greater freedom in responding to life situations.

Priestley's way to the unconscious is through improvised music. She describes the self in terms of its 'inner music', which is 'the prevailing emotional climate behind the structure of one's thoughts' (Priestley 1975, p.199). Although it is outwardly expressed in improvised sound or music, a person's 'inner music' is not her or his musicality or musical potential, but rather the core of the psyche – where the unconscious resides. So, the improvised music is 'projective' in the sense that it is a manifestation of the unconscious. As Bruscia (1987) succinctly states, 'it reveals the unconscious drives and feelings of the id, as clothed by the conscious ideas of the ego, and controlled by the rules of the superego' (p.157).

Priestley's understanding of the self is also shaped by Melanie Klein's understanding that 'there is a fragile ego existent from birth imbued with a strong fear of disintegration' (Priestley 1994, pp.161–168). Klein asserts that this fear leads the infant to split off the 'good' or gratifying parts of its mother from the 'bad' or denying aspects. This split later evolves into the defence mechanism of projective identification in which a person projects parts of her or himself on to another. If one projects bad parts of the self, the object of these projections is felt to be persecutory. If one projects good parts, one feels depleted and idealizes the other. To develop to one's fullest potential one must become aware of these projections and integrate them into one's self (Priestley 1994, p.166).

Priestley later came to embrace Jung's concept of the 'shadow,' 'that region of the mind which contains lost memories, impulses, instincts, and ideas which are not acceptable to the ego-consciousness and are therefore repressed' (Priestley 1994, p.231). If a person either rejects the shadow part of the self totally, or projects it on to others, he or she is said to be only two-dimensional. The shadow dimension must be acknowledged and accepted for the self to be well-integrated.

Clearly, consciousness, as the awareness of one's thoughts, feelings and reactions, is central to Priestley's notion of wellness. Conversely, pathology involves the repression of conflicts, unacknowledged aspects of the self and defence mechanisms that reside in the unconscious. Defence mechanisms are

unconscious steps taken to protect oneself from perceived dangers (Priestley 1994, p.169). They include repression, denial, splitting, projection, introjection, suppression, regression, isolation, intellectualization, avoidance and identification. Defence mechanisms are a normal and necessary part of psychic development because they help contain some of the overwhelming anxiety that would otherwise be caused by the awareness of very threatening feelings, thoughts, impulses and memories. However, if these defence mechanisms become too elaborate they can draw energy away from the rest of one's life activities (Priestley 1994, pp.169–180).

Thus, to be a fully functioning adult requires bringing into consciousness the images and memories one has stored in the unconscious, and to be aware of 'childish' attitudes that have become frozen by unexpressed painful emotions (Priestley 1975, p.193). In other words, by unearthing unconscious material one can expand one's consciousness and enable one's psychic energy to flow freely.

Since the psychic energy that Priestley describes resides in the id, wellness as free-flowing psychic energy requires an interaction and balance between the id, the ego and the superego (Priestley 1994, p.170). To maintain one's health or well-being, one must continually bring into consciousness where this energy is blocked by repressions and other defence mechanisms, and to unblock it, or mobilize it, and direct it positively. It is the unexplored unconscious processes which constitute the obstacles to free-flowing energy.

The sound of one's energy flow is one's 'inner music'. Its outward expression through music will flow freely to the extent that one's inner music is not blocked. The aim of Analytical Music Therapy, then, is to be able to recognize, through music, where the psychic energy has become blocked and what has caused it to become blocked, and to mobilize the energy so that it freely flows between the superego, ego and the id, bringing one's unconscious processes into consciousness. Thus, wellness requires insight and understanding as well as expression of feelings and a release of energy.

Interpersonal concepts

In Analytical Music Therapy, how we relate to and communicate with others is central to wellness. We have interpersonal freedom when we are not hindered by rigid defence mechanisms. Defence mechanisms can restrict interpersonal freedom in that they are patterned ways of responding to situations based on painful past interactions and relationships. If, for example, a person had grown

up in a damaging emotional environment, the damaged child can live on shaping the responses of the adult, especially in interpersonal relationships. According to Priestley, many difficulties in adult relationships result from projecting unintegrated aspects of one's self (often the so-called 'bad' parts) on to other people. A person who has not resolved past conflicts tends to seek relationships which re-create these conflicts, often reinforcing her or his defences even more strongly (Priestley 1975, p.13). The aim of therapy, then, is to provide corrective emotional experiences for the client and to create new emotional options by breaking patterned responses to situations. The process is not one of attacking defences, but rather involves 'making a safe space for exploration of feelings that allows the defences to be gradually loosened, acknowledged through naming of issues and responses (but not necessarily named in defences terms) and then relinquished to be replaced by more healthy, adaptive responses' (Jane Edwards, personal communication, October 2000).

Transpersonal concepts

Unique to Priestley's theoretical framework is what she describes as 'the ineffable'. It can be considered transpersonal, although she does not use the term *per se*. She describes moments when, while the therapist and client are improvising, the music changes quality and begins to hold the therapeutic couple:

> The therapist may feel that the music has become greater than the two of them and then he feels that it is playing him. In fact, instead of being the player he feels that he has become the instrument. At such a time there may be an alteration of consciousness with the act of playing the music with his fingers on the piano creating the lower end of the quivering continuum, reaching up to a lofty area of feeling and thought in a quite different climate. One comes out of such an experience altered, one has lost some of one's constricting individuality and gained a feeling of a greater breadth of being. (Priestley 1994, p.321)

Priestley refers to this type of experience as a 'receptive creative experience' (RCE) taking place in the 'Eternal Now', where our sense of time is altered and we stand still and wonder. These 'sacramental' experiences cannot be produced at will; they just happen, although both players must have a certain degree of empathy and openness. That is, these experiences are unlikely to happen if either the client or the therapist is resistant to the musical process. Priestley (1994) writes, 'Music, at such times, creates us, we no longer create it [and] this

kind of music seems to be experienced in an extra dimension… It is as if the music has already been composed' (p.321). Often after such an experience, the players share its wonder in a prolonged and rich silence, words not able to express its 'ineffable' nature.

Priestley believes that these experiences are a by-product of the improvisation but are not essential for good therapy to take place. However, they might provide the client with an experience of closeness which he or she may need, or joy which he or she may have lacked, and as such, may be very beneficial. In Priestley's words, 'I do not know what the inward and spiritual grace is but it is a very real presence' (1994, p.321).

Dynamics of the therapeutic relationship

Transference

Transference is a process by which a client attempts to relive, in current relationships, the unfinished business from former important relationships in her or his life (Priestley 1975, p.238). In the therapeutic relationship, it refers to the client's projections on to the therapist. Furthermore, in Analytical Music Therapy it can also include the client's projections on to, or in to, the music, or on to a musical instrument. Transferences may be conscious, pre-conscious, or unconscious. Transferences can be either positive or negative. That is, the client can project positive or negative qualities on to the therapist, instrument(s) or music.

Countertransference

In the therapeutic relationship, countertransference refers to the therapist's emotional reactions to the client. Priestley defines three kinds of countertransference. The first, which can be destructive to the therapeutic relationship, is 'the therapist's transference of [her or his own] projections on to the client' (Priestley 1975, p.240; Scheiby 1998, p.217). Priestley refers to this as classical countertransference. The second, which can be very helpful, is 'the therapist's identification with unconscious feelings, self-parts (instinctive self, rational self, or conscience) or internal objects of the client, which, [when] conscious in the therapist, can serve as a guide to the client's hidden inner life' (Priestley 1975, p.240). Priestley refers to this as complementary countertransference. The third type, referred to as emotional countertransference, consists of 'sound patterns that reflect the music therapist's sympathetic resonance with the client's feelings through emotional and/or somatic aware-

ness' (Scheiby 1998, p.218). Often while playing, the therapist may experience emotional and/or somatic awareness of some of the client's feelings, of which the client is not yet consciously aware (Priestley 1994, pp.87–88). Often, the first awareness of these emotions, and/or the reasons behind them, comes from the music therapist's countertransference in the music.

Countertransferences can also be either positive or negative. Priestley (1994) notes that while it seems obvious that negative countertransferences should be analyzed, positive countertransference should also be examined, 'as it might fall into seductive patterns of the early symbiotic relationship, making growth and the development of a healthy sense of separateness difficult...to achieve' (p.82).

Resistance

Resistance is when the client opposes the therapeutic process in a variety of ways that defeat the objective of change (Scheiby and Montello 1994, p. 220). In Analytical Music Therapy, resistances may be expressed verbally or musically. Musically, resistance may be the client's avoidance of using the voice and/or musical instruments, or may be heard as a fixation on a certain musical idea (Scheiby and Montello 1994, p.220). Resistance also may be expressed musically in clients who willingly participate in the music but avoid verbal processing of the musical content (Austin and Dvorkin 1993, p.425). Verbally, resistance may be seen in the form of clients taking up most of the session time talking and leaving little time for playing music, perhaps fearing the powerfully deep connection with the music. Resistances can be used to aid in the therapeutic process when brought into the client's awareness at the appropriate time.

Therapists also can be resistant to the therapeutic process (Austin and Dvorkin 1993, pp.428–429). They may be defending against feelings of inadequacy, either in their ability to go deeper into the therapeutic process or in their abilities as musicians, or their own unresolved issues may be getting in the way of their objectivity (Austin and Dvorkin 1993, p.428). The therapist's resistances must be addressed in supervision or else they can be very detrimental.

Working Alliance

Priestley uses Greenson's (1967) definition of the working alliance as a 'relatively non-neurotic, rational relationship that the client forms with the therapist in order to accomplish the goals of therapy' (Priestley 1994, p.73). Unlike the more hierarchical nature of transferences, which are reminiscent of

child–parent relationships, the working alliance is an adult-to-adult relationship in which the client takes responsibility for working through her or his problems. The interpersonal dynamics which shape the working alliance are played out through transferences, countertransferences and resistances. It is in the working through of these dynamics that interpersonal freedom can be achieved. So, for Priestley, a healthy alliance is a model for interpersonal freedom. In Analytical Music Therapy, the working alliance is enhanced by the musical relationship between the client and therapist, perhaps precisely because the music is co-produced or created together.

Treatment procedures

The techniques that Priestley developed are what have made her model so innovative and have formed a crucial bridge between psychoanalytic theory and music therapy. These techniques were developed as a way to incorporate psychoanalytic concepts effectively using an improvisational musical medium, which Priestley believed would enhance the therapeutic process by reaching the unconscious more directly – the music being a nonverbal manifestation and expression of unconscious processes. Pre-recorded music and/or pre-composed music may also be used effectively.

In typical Analytical Music Therapy sessions, an issue is identified and a title is then suggested, usually by the therapist, on which to improvise. The Analytical Music Therapy technique used depends on the issue being explored. Sometimes, the client and therapist improvise without a title or focus. Feelings and reactions arising during the improvisation are usually verbally processed following the improvisation. Art, clay sculpture, imagery, movement or body work are also ways in which to process these feelings and reactions (Priestley 1975; Scheiby 1991, 1999).

The following are very short descriptions of typical techniques used in Analytical Music Therapy:

Holding

The holding technique is the safe, yet unrestricting, musical support of the therapist and is used to assist the client to explore conscious and unconscious material. The client is encouraged to experience fully her or his emotion to its climax, through sound expression, while being held emotionally by the musical matrix of the therapist (Priestley 1975, p.121).

Splitting

The splitting technique is used to explore experiences that involve conflicting elements or opposing forces, and when a person has projected parts of the self on to another. The therapist facilitates improvisations that reinforce the exploration and integration of polarities. Becoming more aware of these unacknowledged aspects of the self helps the client to introject them (Priestley 1975, p. 123).

Investigation of emotional investment

This technique is used to explore how the client feels about various situations or people. It helps the client compare the relative feelings and put them into perspective (Priestley 1975, p.125).

Entering into somatic communication

Entering into somatic communication is a technique employed when a client's emotions are expressed through physical symptoms. These symptoms may be outward manifestations of a repressed emotion, and, in this technique, the assumption is that by exploring the symptom, the emotion will be released through the music, which then allows the client to experience it (Priestley 1975, p.127).

Guided imagery, myths and dream work

These are techniques used to provide a bridge to unconscious material. Improvisations may be structured around myths, dreams or guided imagery experiences, or the client's music may be used in playback form for a guided imagery experience (Priestley 1975, pp.129–136).

Reality rehearsal

Reality rehearsal is a technique used when the client has chosen a direction to be taken in life and needs to try it out in a safe place. The technique allows the client to raise, face and overcome, or come to terms with, all the inner fears, anxieties and destructive urges which get in the way of achieving a desired aim (Priestley 1975, p.137).

Wholeness

Wholeness is a technique in which the client improvises alone as if he or she were perfectly whole. This technique gives the client an experience of com-

pleteness within the music which gives her or him a goal to strive for in her or his life (Priestley 1975, p.138).

Exploring relationships

This technique involves acting out different kinds of relationships musically. It can be used in a similar manner to the splitting technique or the emotional investment technique (Priestley 1975, p.138).

Affirmations

This technique is designed to induce a resurgence of faith and hope. It allows the client to re-experience moments of joy and peace in her or his life which can, in turn, have a reviving affect on the person (Priestley 1975, p.140).

Subverbal communication or free association

Subverbal communication or free association involves improvising together without a title, focus or roles. It is used to explore the nature of the client's energy flow (Priestley 1975, p.140).

Patterns of significance

This technique is used to explore the inner patterns and feelings surrounding significant life events such as birth, marriage, death, and so on (Priestley 1975, p.141).

Programmed or spontaneous regression

Programmed or spontaneous regression involves the client improvising as if he or she had returned to an age significant to her or him as opposed to examining memories of actual events. Through this technique, the client can tap into unexpressed emotions from the past (Priestley 1975, p.143).

New directions

When Mary Priestley developed Analytical Music Therapy, along with colleagues Marjorie Wardle and Peter Wright, in the early 1970s, it was very innovative to use psychoanalytic constructs as a basis for interpreting a client's responses in music therapy. In fact, it was her own experiences in psychoanalysis that influenced Priestley's thinking in this way (Hadley 1998a). After sharing her techniques in her first music therapy book, *Music Therapy in Action* (1975), music therapists, primarily from Europe, sought Priestley out in order

to be trained in Analytical Music Therapy. Students were trained in pairs, each experiencing the model as both therapist and client under Priestley's supervision. Priestley termed this training 'Intertherapy'. All of her Intertherapy students were strongly encouraged to undergo their own personal psychoanalysis in addition to their Intertherapy training. Due to the varieties of psychoanalysis that analytical music therapists choose to undergo, in addition to Priestley's encouragement to take from her what they could use and incorporate it into their own approach, analytical music therapists tend to practise in slightly different ways.

The first Intertherapy couple Priestley trained was Johannes Eschen and Amanda Warren, followed soon after by Ole Teichmann and Colleen Purdon. Other noteworthy student pairs include Inge Nygaard Pedersen and Benedikte Barth Scheiby, and Ernst Walter Selle and Alison Schaeffer. Some of Priestley's students went on to train others in Analytical Music Therapy and to use and extend its concepts in training, supervision and research. After his training, Eschen and his colleague Dr Schily organized the *'Mentorenkurs Musiktherapie Herdecke,'* (music therapy mentoring course) which was held from 1978–1980. Priestley was one of the music therapy mentors invited to present seminars and lectures in her model of music therapy. These lectures can be found in her book, *Essays on Analytical Music Therapy* (1994). In this course, Teichmann, Purdon and Eschen were all instrumental in training the students in Analytical Music Therapy, providing individual and group sessions and supervising the Intertherapy training. The students in this course included: Inge Nygaard Pedersen, Benedikte Barth Scheiby, Mechtild Langenberg, Wolfgang Mahns, Joachim Ostertag, Eckhard Weymann, Tilman Weber, Rosemarie Tuepker, Frank Grootaers, Rosemarie Fueg, Nikolaus Buzasi, Ulrike Winter, and Ludwig Streicher.

As Priestley encouraged, her approach has been developed in a variety of innovative ways. Some notable examples include developments by Johannes Eschen, Inge Nygaard Pedersen and Benedikte Barth Scheiby, Mechtild Langenberg and Susanne Metzner.

When developing his training course, Eschen created what he terms *Lehrmusiktherapie* (training music therapy), an expansion of Priestley's training method.[2] *Lehrmusiktherapie* comprises three parts: individual music therapy and group music therapy, followed by the traditional Intertherapy. Although sometimes trained in pairs, as in Priestley's training approach, Eschen encouraged the Intertherapy part of the training to be done in groups of three. In this way, each student is able to experience all three roles (patient, therapist, and

supervisor), very much like the original experience of Priestley, Wardle and Wright. For example, student A is therapist for student B whilst student C co-supervises with the trainer, B is therapist for C whilst A co-supervises, and C is therapist for A whilst B co-supervises. This way, there is less role confusion than might be found when training in pairs where A is therapist for B, and then they switch roles, under the supervision of the trainer. Other innovations by Eschen include his use of the Ammon concepts of thinking processes in music therapy. That is, that there are different modes of thinking: primary process thinking which is dream-like thinking that ignores the categories of time and space; secondary process thinking which is governed by the reality principle; and tertiary process thinking which is a state of mind where one can oscillate between primary and secondary process thinking. Tertiary process thinking is possible in 'facilitating environments' in which people feel safe. Eschen suggests that within Analytical Music Therapy improvisation, such a 'facilitating environment' for tertiary process thinking can be created. Within this framework, Eschen developed what he terms 'associative improvisation' which involves improvising according to one's free associations. In these 'daydream improvisations' only the starting situation or emotion is agreed upon, as opposed to 'descriptive improvisations' where improvisers follow a pre-determined plan. He also distinguishes 'associative improvisation' from what he refers to as 'material-oriented improvisation' where improvisers concentrate on musical aspects of the improvisation. Finally, in group music therapy, Eschen developed the *'Beziehungsrondo'* or relationship rondo, in which there is an alternation between full group and various pairs or subgroups. This leads to a variety of different connections with others in the group, which can produce very interesting interpersonal dynamics.

In a similar manner to Eschen, Pedersen and Scheiby also incorporated individual and group music therapy experiences into their training programme in Aalborg, prior to the Intertherapy experience (Scheiby and Pedersen 1999). Furthermore, they changed the design of the supervision aspect of the Intertherapy experience. Instead of both students being present for the supervision, each student received supervision privately. Furthermore, expanding Priestley's explorations in psychodynamic movement, Pedersen and Scheiby incorporated concepts of bioenergetic body work and relaxation into their training (Suzanne Metzner, personal communication, 30 July 2001). Learning to communicate with clients who are preverbal or nonverbal is essential and necessitates the understanding of body language.

Trained by Pedersen and Scheiby, Susanne Metzner uses psychodynamic movement (i.e. improvised movement with improvised music) as the 'heartpiece' of her training method, while also emphasizing free improvisation. The training begins with various exercises for self-awareness of one's own body and the awareness of others' bodies and their movements. Metzner then gets students to explore, through movement, developmental steps from very early childhood to adulthood (including sexual and erotic subjects). Finally, students lead groups and receive supervision on their individualized approaches. Metzner's framework focuses on 'bodily countertransference and the object-relationship that becomes concrete in gestures, movements, and the way the room and the atmosphere are influenced by the client/student' (Metzner, 30 July, 2001). In terms of musical improvisation, Metzner's interest lies more with the musicological and interactive aspects rather than with fantasy and imagination and so she places more emphasis on non-referential than on referential improvisation.

Since leaving Aalborg, Scheiby has developed her own private training programme in New York, where Intertherapy is an essential part of the training. Students are required to undergo individual Analytical Music Therapy for at least one year. After this, they undergo half a year of Intertherapy training in pairs, which is followed by a year of individual Analytical Music Therapy supervision sessions and a half to a whole year of Analytical Music Therapy group supervision. Scheiby describes four competency areas which are focused on in the training (Scheiby 2001). These are:

1. *Personal* competency – ability to *be* therapeutically relevant *(being*),
2. *Technical* competency – ability to *act* therapeutically relevant (*doing*),
3. *Artistic* competency – ability to *create* in a therapeutically relevant way (*creating*) and;
4. *Theoretical* competency – ability to *think* in a therapeutically relevant way (*thinking*).

Throughout the training, students write journals/logs of their experiences, which are submitted to the supervisor. When the training, which involves clinical and theoretical aspects, is completed, students are required to write a paper summarizing the experience accompanied by a tape containing examples of significant musical moments from the sessions.

Concentrating on the emphasis placed on *relationship* in Analytical Music Therapy, necessitated by the common musical improvisation peculiar to AMT,

Mechtild Langenberg has developed the concept of what she terms the 'resonator function' (Langenberg, Frommer and Tress 1995; Langenberg, Frommer and Langenbach 1996; Langenberg 2001). Langenberg suggests that 'in the transference relationship of the therapeutic situation, a particular quality is created in that a direct resonance – a sympathetic vibration between the therapist and the patient established by the sounds and the playing – is perceptible' (Langenberg 2001, p.273). That is, the patient and therapist resonate with each other, making use of their own personal instruments when relating and understanding each other. This concept of the resonator function is not only relevant in clinical practice, where the therapist must be aware of her or his own thoughts, feelings and fantasies in order to best meet the needs of the client, but also in supervision and research. In supervision, the therapist restages the relationship dynamic from the therapy session, and the therapist and supervisor, through another instance of the resonator function, 'work toward meaning through a countertransference analysis' (Langenberg 2001). Langenberg (Langenberg *et al.* 1995; Langenberg *et al.* 1996) also utilizes the resonator function in her clinical research methodology. In this research methodology 'the interactive work of music psychotherapy treatment is examined using the methodological principle of "triangulation of perspectives"', that is, examining the perspectives of the patient, therapist and independent observers (Langenberg *et al.* 1995, p.97). It is based on the premise that all participants are capable of perceiving, through the resonator function, 'affective content of the material produced in treatment, as well as its aspects relative to the therapeutic relationship' (Langenberg *et al.* 1995, p.100). All participants are asked to describe associations, feelings, thoughts, images, mental pictures, and stories that arise upon listening to the music, no matter how chaotic they seem. This relatively unstructured verbal material is then categorized in terms of its 'qualities', which are differentiated in terms of content and feelings. The descriptions are also organized in terms of 'motifs' through a process of open coding. Finally, interindividual comparisons are made between all participants. From these, connections between motifs found in the texts and aspects of the patient's biography, psychodynamics and treatment can be seen.

Priestley developed Analytical Music Therapy primarily for adults, either those who were interested in personal growth or those with mental health problems. Later she expanded her work to include children. Since then, analytical music therapists have expanded the clientele from adults seeking personal growth and those with psychiatric conditions, to include clients of all ages with a variety of disorders, including neurological traumas, stroke, traumatic brain

injury, multiple sclerosis, Lyme's Disease, cancer, amputations, coma, heart condition, diabetes, cerebral palsy, Parkinson's Disease, geriatric clients, victims of neglect, sexual, physical or emotional abuse, clients with eating disorders or substance abuse problems, and intellectually disabled clients. Some clients have demonstrated little or no verbal abilities. Thus, it has been necessary to develop ways of communicating with this type of client on a preverbal level, so that musical and body communication can stand alone without the medium of words, if necessary (Scheiby 1991, p. 274).

Conclusion

It is unfortunate that Analytical Music Therapy has never received the recognition in the UK and the USA that I believe it deserves. It has been much more widely accepted and practised in Europe. However, the theoretical bases of Analytical Music Therapy have been influential in a variety of ways. Many music therapists, whilst not trained in Priestley's model of Analytical Music Therapy, now practise what is referred to as analytically informed music therapy, although they may not primarily use improvisation, and they may not have undergone the same types of training procedures necessary for becoming an analytical music therapist of Priestley's type. Priestley's method has, however, laid the groundwork that has provided the framework for analytically interpreting a client's responses in music therapy.

Notes

1. This chapter was largely inspired from my dissertation research in which I explored the life and work of Mary Priestley and Clive Robbins (Hadley 1998a; see also Hadley 1999). I found this research very stimulating and enlightening. In meeting Mary Priestley and learning about her life and work, and by undergoing my own sessions in Analytical Music Therapy (see Hadley 1998b), I was struck by the power of this as a music therapy method.
2. For further elaboration on *Lehrmusiktherapie* see Chapter 2.

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Part Two

CHAPTER 4

Some Considerations on the Treatment Techniques of Psychoanalytically-Established Music Therapy

Mechtild Jahn-Langenberg

> We play what comes into our heads, and allow ourselves to be guided by that inner voice which demands to be expressed outwardly. (Langenberg 1988)
>
> Go and search for your own tone, your instrument, your place in the room, everything which pleases you. Try once again to be as curious as a child about what you hear. (Invitation to the patient for the first improvisation)

A room with instruments and a variety of possibilities for stimulation: touching, beating, striking, stroking, hitting, plucking, blowing; taking in the hand, the arms, the mouth; hard, soft materials, wood, metal, fur; voices, closeness to and distance from the body and an offer of a relationship with a therapist who plays along.

The invitation to occupy the special playing room means first sensing one's own needs and, at the same time, accepting an offer of interaction.

With this atmospheric introduction to a special psychotherapy procedure, basic conditions for the encounter with treatment experience are established. These steer one's attention to a specific, the creative play space of the early development stage. In the sense of a culture space, they retain a life-long importance (as a space for experiencing) for the emotional health of humans.

Winnicott's concept of the transition space corresponds to this phenomenon. Challenged to play and to deal creatively with ambivalent tensions, humans cope with their own individuation process (Winnicott 1979).

Above and beyond the treatment of reality, further conditions for the therapeutic treatment as a necessity are required. The human ability to 'treat' playing, acting, and fantasising reality becomes a psychotherapy procedure.

Music therapy as a clinical, artistic and scientific subject – a university discipline in Germany which has developed into an academic profession – has been searching more and more within the various music therapy fields of practice for reference systems of different theories, such as psychoanalytic concepts, humanistic psychology, behaviourism, communications theory concepts, and so on. At the same time, in the mutual work with corresponding subjects such as music, psychology, pedagogy, medicine, and the social sciences, a more uniform treatment doctrine is growing out of this genuinely interdisciplinary subject. The integration into psychoanalytic psychotherapeutic competencies and their techniques of intervention is the subject of this contribution.

The necessity of combining psychotherapeutic procedures increasingly arose from the conditions of clinical daily life, challenged by the variety of disturbances which require diagnosis, indication and the development of total treatment plans. In stationary, partially stationary and also ambulatory settings, the experience- and action-oriented methods of psychotherapy seemed to promise greater success – in part they form the decisive means of access to patients in the course of the treatment.

Music therapy as a psychotherapy procedure in the area of psychogenic illness has the goal of establishing itself as an independent, recognised treatment method within the health system. On the way toward professionalization and the development of clinical standards for this interdisciplinary subject, proof of a scientific and empirically evaluated procedure was required from music therapy (Grawe, Donati and Bernauer 1994).

Alongside the institutional development of the integration of music therapy into treatment plans (Heigl-Evers, *et al.* 1986; Janssen 1982), clinical applications and research which came about with reference to the needs and functional characteristics of relevant medical institutions were presented (Langenberg, Aigen and Frommer 1996; Langenberg, Frommer and Tress 1992, 1994, 1996).

Music therapists, doctors, and treatment teams developed the diagnosis, indication, and modification criteria for the treatment doctrine for specific

cases, so that the process of the total treatment could be shaped in an individual- and course-oriented manner (Langenberg 1986).

Music therapy as a psychoanalytically-established method

Music therapy is to be understood as a modification of analytical psychotherapy, which came about in the wake of institutional developments at, for example, the Clinic for Psychosomatic Medicine and Psychotherapy in Düsseldorf. The treatment method is rooted in the Analytical Music Therapy of Mary Priestley (1975, 1983) and Johannes Eschen (1982, 1983), as well as New Music's understanding of music (see Karkoschka 1996). Through increasing professionalization, psychoanalytically-established music therapy (Langenberg 1988) could take on the functions of an independent psychotherapy procedure within the framework of an integrated treatment plan (Heigl-Evers *et al.* 1986) in a clinical setting.

A specific of active music therapy is the active relationship between patient and therapist. Encounters take place within the playing space of the mutual musical improvisation and in conversations which are held before and after playing. With this, a comprehending occurs, a putting into words of the experiences had during the playing process and the intrapsychic and interpersonal phenomena which came up then.

In the triad Encounter – Produce – Manage, the treatment process, understood to be the interactive act of improvisation as a re-setting in scene, is carried out.

The basic rules of an encounter in the music therapy situation are: 'We play what comes into our heads, and allow ourselves to be guided by that inner voice which demands to be expressed outwardly, even if it seems like nonsense or absurd to us!' (Langenberg 1988)

This is the expanded analytic ground rule, expanded in order to play with the possibilities in and with music. Using the method of free improvisation, a mutual musical product is produced: the treatment piece. Through the production of this piece and in the comprehension via words of what has been experienced, those involved manage their treatment contract. To this setting belongs a room with instruments. First, the therapist's piano, which has been freed of its wooden covering so that the sounding board inside can also be played. A further expressive palette of instruments, enticing and inviting to be touched and explored, is made available. There is a second piano, a violin, a cello, a

psaltery, percussion instruments, a chromatic xylophone and metallophone, non-European instruments, flutes, and so on.

Previous musical knowledge is not necessary, but the willingness to follow one's own spontaneous playing impulse, to be as curious as a child again about what one hears, and to literally become one's own ideas again, is.

The lively encounter and relationship process incites feelings, fantasies and pictures, which are indications of the staging of subjectively-experienced, internalised interpersonal relationship experiences and conflicts from earlier developmental phases. In the transference relationship of the therapy situation, a unique quality is thus produced in that the direct resonance arising from the sounds and mutual playing can be perceived with the senses. A room, a space is created where subconscious fantasies become audible. A psychodynamic understanding of the specific encounter situation is facilitated.

The perception attitude of this psychoanalytically-established music psychotherapy in the sense of a personal instrument of relating and understanding was termed the 'resonance function' in an earlier work (Langenberg 1988). Alongside the ability to co-vibrate, to be audible and palpable within the encounter process, the idea of 'instruments' is contained within this term, so that the special quality of the transference relationship in music therapy becomes clear. Tone and relationship shaping within music occur in the time when the players in the encounter enter into a sensually perceivable, listening and feeling relationship (Langenberg, Frommer, Seizinger and Ressel 1994). Within the security-giving playing room, times of binding and separating can be experienced.

The treatment instrument of the resonance function implies psychic and physical answers in the treatment process: the meaning of the daydream experience, an oscillating between primary and secondary processes during the improvisation, the setting of inside and outside into relationship, now – this minute – tomorrow (thus the shifting of time in music), the correspondence of 'me' and 'you,' and the material and the ideal.

The specifics of music therapy are, alongside the space to play and speak, techniques of fiddling around with the improvisation process as well as the psychotherapy processes. Psychoanalytically-established music therapy received valuable inspiration from the psychoanalytic interaction method (Heigl-Evers and Ott 1994). In the Answer Principle, parallels to the position of the selectively authentic, palpable, and active in the sense of mutually-playing music therapist are found.

The provision of an affective experiencing within a relationship forms the basis of the treatment technique, and makes a development-supporting field of stimulation available. Within music therapy work, the question is one of a process toward the derivation of meaning within an attuning play between regressive and aggressive progressive conditions. The relationship process moves between these poles, and provides identity-challenging qualities (Langenberg *et al.* 1988; 1994). The process challenges identity.

The players encounter each other in sound and relationship *gestalt*-shaping within the music, and enter into a sensually perceptible, hearing and feeling relationship. This relationship is experienced in movement and change through the shaping of time during the production of the mutual product. The patient's treatment contract, worked out in initial sessions through improvisation and the understanding of the treatment piece as a setting-in-scene and mirror of specific relationship occurrences, often suggests itself as the wish to develop individual contours. To draw attention to oneself, to dare to argue openly, to rub someone the wrong way – these all become possible without danger through the sounds which induce polarity and the principle of order in the shaping of time in music. The derivative of playing (Winnicott 1979) makes a space for experiencing and understanding available, in which a relationship where the partners are more attuned to each other can be worked on.

The providing of and dealing with affective experiencing in the resonance-giving posture retains a special meaning, in that the music therapist allows her- or himself to be playfully tangled up in dialectively constructive tension. The setting-in-scene repeats anaclitic relationship patterns which are often observed in the patient. However, it also reveals what are to be understood as signal parts of affect as early as in the first session (Krause 1988). Affective expressions as indication functions often arise in improvisatory playing earlier than they can be put into words in the conversational part of the treatment, i.e., than they can have consciously assigned meaning. The work on the perception of affect, clarification and fine-tuning in the relationship to the therapist who plays along, experiences, and yet maintains a sense of her or his own person, forms the primary goal of music psychotherapy.

The manner of working in psychoanalytically-established music therapy borrows its framework from psychotherapeutic medicine and psychosomatics, through which psychotherapy treatment conditions are created. That means a differential diagnostic process, the deriving of the treatment indications and goals from the background of a psychoanalytical 'illness doctrine'.

The treatment process, with its experience-oriented focal point working within the playing room of musical action-taking, integrates itself into the total treatment plan of a psychotherapy station or day clinic. There, in multi-factoral access to the patient and, depending on the indication, libidinous and aggressive impulses can be activated and differentiated through, for example, psychoanalytical interactional group therapy, or further special therapies such as *gestaltung*-, body-, and social-therapy. These impulses can be found, shaped, and brought to expression in the sense of actively being tried out in the mutual playing/improvisation with the music psychotherapist (Langenberg 1986).

However, before a treatment contract can be drawn up and the treatment setting, methods, and goals worked out, a professional diagnosis must be made.

In an ambulatory first encounter situation, the co-operation between the psychosomatist and the music therapist shapes the complementary and contrasting findings. The following case study of Mr R's special relationship dynamic within an improvisatory playing session highlights an example of where, as a result, music therapy is indicated. In this project dealing with the process toward meaning, two spaces for unfolding (i.e. the potential of verbally or musically shaping and forming) could be offered to the patient: the psychoanalytical first interview with the doctor, and the music therapy setting with its invitation to mutual, intuitive improvisation.

> Mr R, a young man about 30 years old, suffered from a functional disturbance of the gastrointestinal tract and had a background of neurotic depression: thus the medical-psychosomatic diagnosis. In the music therapy session, in two improvisations he staged his latent autonomy-dependency problem with his mother, and insecurity in regard to his manly identity and assertiveness, readily understandable due to his lack of a father figure in decisive development periods.
>
> Forcing himself to be ready to play, and unsure of his own protective barriers, he first freely experimented with numerous instruments. He appeared unwilling really to get involved with any place, any form or any sound. Only after turning to the second piano, next to the therapist, was his deep interest captured. He opened up to a playing dialogue, which, however, ended up being symbiotically merged together and finally lost. The attempts of the therapist to set borders and differentiate against and alongside his harmonically seductive playing were experienced by the patient as being aggressive. In masterful reaction forming, he transformed the 'attack' into obedience and undifferentiation.

The following findings were accumulated from the evaluation of the improvisation in the music therapy first encounter; they are listed as key words. From the first improvisation: structured; agile; contrary; without dynamic; long time not involved; consciously avoiding; selfish; demanding; to want help but not accept it – due to fear?; what is required is difficult to make understandable; at the end 'one man band'; in his choice of instruments an approach to the tones of the therapist; two women are playing; much changing; restless; interruptions.

From these associations in the first improvisation, three hypotheses about the relationship dynamic which could form the basis for a treatment contract and treatment goals with the patient can be derived:

1. A bit isolated.
2. Tendency toward setting of borders (interruptions) alternating with merging.
3. Gradual approach to the therapist's instrument.

In the second improvisation, the typical object relationship of this depressed patient who reacts with severe symptoms in the stomach/intestinal tract was set in scene much more clearly. Here again associations to music follow, which transport the non-verbal occurrences in the playing and encounter process on to another symbolic level: searching for, finding, and losing the mother (the supporting object) again; being lost in the wide, wide world; baiting; going into the playing together; sadness; a wide horizon empty of people; do the partners have the same value and the same rights?; melancholic; opposite pole; closed structure; involvement; pasty; irritated.

These associations to music resulted in the following two hypotheses:

1. Mourning about a loss.
2. Feeling good within a supporting relatedness, instability when the support gives way.

When the two diagnostic situations are compared, it becomes clear that more emotions show themselves in the music therapy session, whereas in the psychosomatic interview the patient's routine answers are noticeable. In music, helplessness and a poverty of resonance become clear; in the further course of the improvisation the patient becomes lost in the sound and merges. The piano, for the patient the instrument of his mother, symbolises 'supporting' as well as 'expecting too much'.

In music therapy, regressive elements and the lack of a middle level between isolation and merging together take on clearer contours than in the psychoanalytical first interview, where, however, symbiotic interests are also experienced in the relationship with the male doctor. In summary, it can be said about such a combined diagnostic process that the patient is experienced on a higher structure level in the first interview than in the music therapy first encounter.

Further treatment planning can be developed from this: which development tasks must first remain in the foreground – the neurotic aspects, or the early disturbed part of the patient?

In the adding to and contrasting of verbal and non-verbal processing spaces, music therapy in combination with verbal psychotherapy offers a differentiated access to the problems of the patients. From the re-staging of the relationship dynamic in improvisatory playing, the indication for the special procedure 'music therapy' comes about. The treatment goal for the patient Mr R could be defined for now as the perception and identification of important relationship-regulating affects. In order to clarify them, to give them meaning, and to classify them as important signals in the assertion of one's own needs as well as the understanding of the partner in the further relationship process, playful experience rooms/spaces are required. In the music therapy findings of the evaluated improvisations, breaks in the dialogue became noticeable when the therapist and the patient got too close. These breaks can be understood as a protective function against over-flooding from external stimulation, especially when a regulation emergency appears in patients with psychosomatic symptoms. These patients often have only the somatic level as a means of expressing such a feeling of emergency and stress.

At this point, please refer to the study done on two improvisations in which the affective participation of patient and therapist as well as the resonance of the listener to the treatment piece first register disconnectedness and distance. In a further development of the ability to relate in the treatment process, a growing perception of the other as well as relatedness are created (Dorrer and Langenberg 1998).

> The patient, a young woman with alternating bulimic and adipose symptoms, experienced for the first time in the answer-giving resonance space of the music therapy situation that her oral 'neediness' and lack of satisfaction could be stilled and satiated. In the course of the therapy, she overcame her fear of being separated from her mother, set in scene sym-

> bolically in the transference relationship with the music therapist and in identification with her instrument, the piano. Experiencing one's own borders and differences, withdrawing one's self and being allowed to approach again were both made possible without danger in the playing space of the free improvisation. Within the treatment, the playing process is just as important as the necessity of putting what has been experienced into words, the comprehending and classifying, the transfer into one's own living world. This translation work and the change from the level of playing to that of words, the oscillation between primary and secondary processes, means a continual challenge and work towards meaning for the therapy situation.

The working group *Qualitative Musiktherapieforschung* (Qualitative Music Therapy Research) was founded in 1991, based on my own preparatory work (Langenberg 1983, 1986, 1988), which was occupied with the description and evaluation of the products of therapy and the working out of the specifics of music therapy actions as psychoanalytically-established methods. The affective and interactive experience and relationship process which goes along with the music therapy improvisation demanded the development of a description and interpretation methodology appropriate to the subject. Although the process of making music seems to be transitory, the process of experiencing can be re-lived when an appropriate readiness is exhibited while listening to the piece. The perception attitude of the resonance function (Langenberg 1988), the personal instrument of relating and treatment, is characterised by the ability to co-vibrate and the perception of inner pictures, alongside a musical instrument way of thinking. All of these can be useful in researching the situation, in that independent people who were not involved in the production process (listeners) can listen to the improvisation and, at the end, note their impressions. Here the instructions are: 'Describe your impressions of the resulting improvisation as freely as possible. Feelings, thoughts, pictures, stories all can be reported – even if they seem terribly disorderly!' (Langenberg *et al.* 1992)

In the descriptions, subjective parts which are determined by the personality of the listener are found, but, just as often, indications of common motifs are found. This leads to the conclusion that what was treated in the process of the therapy playing encounter can be tuned into again through the resonance function. In the sense of perspective triangulating (Denzin 1970; Flick *et al.* 1991), after the session both the patient and therapist write a spontaneous protocol; thus, the improvisation becomes subject to a musical analysis – a description of its form from the perspective of the musician/composer. In a dis-

cursive–dialogical research process, motifs are inductively drawn from the material and related to the case study. This motif-reconstructing understanding is applied to the evaluation of the patient's treatment piece after the interval of a year.

> She had suffered for the last 10 years from frequently recurring migraine-type headaches, and had a depressive–compulsive personality with severe self-worth problems. Her original isolation and affective coldness could be developed into the ability to bind, as demonstrated through the resonance method, through the music therapy treatment process (Langenberg, Frommer and Tress 1992,1996).

Just as in this treatment, in another work on ambivalence conflict with a narcissistic patient, the dialectical process between merging and separating conditions brought out the typical relationship pattern alongside the contradiction experiences (Fischer 1989). The way in which the primary motifs progressively change in the course of treatment, derived from the resonance to the improvisation, could show that, on the one hand, opposites are capable of remaining alongside each other, but on the other hand, movement, shaping, and re-classifying are experienced and integrated when the resonance-giving space of the music therapy procedure is used (Langenberg, Frommer and Tress 1994).

Some results of the psychosomatic project

Our methodology towards understanding the music therapy treatment piece fundamentally pursues a knowledge-expanding character, not a knowledge-securing goal in the sense of the deductive verification of hypotheses leading from assumptions in the sense of nomological research (Jüttemann 1992).

Through the comparative analysis of empirically–hermeneutically derived data, we contribute to the explanation of inner sensory contexts. The subjective and inter-subjective processes which accompany music therapy are the research material. In the case of the patient with *colitis ulcerosa* a partly stationary progressive examination takes place instead of an ambulatory treatment. Here, master's and doctor's degree candidates work on the same case using different methodologies and approaches.

In a comparison of the patient's third, seventeenth and forty-fifth sessions, the characteristic 'motif overview' shows the patient's process of change from clinging, insecure diffuseness in relationship behaviour, towards the building of clear contours in the differentiation of personal forms of expression. Motifs

of the third session are avoidance, concealment, armour, refusal, opening, and endlessness. Those of the seventeenth session are strength, resistance, unity/differentiation, setting limits, mutuality, pleasure, closure. The forty-fifth and last session of the day clinic treatment brings out the following motifs: learning to walk, remembering, risk, orientation, and support. The improvisations from the beginning sound very restrained and diffuse, the patient on the chromatic xylophone can hardly be heard next to the piano being played by the carefully space giving therapist. A quotation from one descriptive protocol reads: 'Two who are dealing with each other very carefully'(Unpublished clinical research material). Or from another: 'There is someone there, but I can't sense him/her'. In the patient's protocol, the room she had in the time of puberty arises as the fantasy of an area for retreat, where she could play the guitar and not feel disturbed. The seventeenth session clearly showed a stabilisation of her personal tone in showing herself and building contours; the establishment of a trusting working relationship between the patient and therapist takes place.

The describer of the improvisation (listener), uninformed about the case, experienced decisiveness and strength, but also a symbiosis between the two players who push forward and gain space. A quotation from a protocol reads: 'To sense it, there is someone there'. Within the framework of a language analysis of this research project, a clearly more differentiated affect language is found after the improvisation than before it. That means that after having gone through an emotional experience in musical play, the connection to the conceptual of the strengthened affect level in the sense of the patient's relationship to herself and the therapist can also be made during a conversation about what had been experienced. The change in the quality of the relationship revealed exciting regulation work (affected regulation) between the two, shown through the resonance to the music and in the conversational part. The problem being worked on was put into these terms by the patient herself: 'I need you differently now than I did before.'

After the forty-fifth session, whose motifs have been listed above, the patient wrote in her protocol: 'The music seems to me to be a short summary of the past six months – first the search for the distribution of roles, then melody and accompaniment.'

In conclusion, based on research the specific process towards meaning of psychoanalytically-established music therapy can once again be presented. Specific treatment techniques for diagnostic situations and thus the

post-diagnosis indications, as well as a period of treatment, can be presented based on several case-related scenarios.

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CHAPTER 5

Analytical Music Therapy with Adults in Mental Health and in Counselling Work

Inge Nygaard Pedersen

Introduction

My first experience with Analytical Music Therapy (AMT) with adults took place during my training period at the *Mentorenkurs Herdecke*, Germany 1978–80. As a mature student at this time, I was part of the experiential training of music therapy (ETMT) for students in the AMT approach as a mandatory part of the *Mentorenkurs*.

In this training I encountered many symbols that emerged during improvisations in individual and group music therapy and in Intertherapy work. All my symbols, in no matter what quality or form, were expressed and articulated through musical improvisations, among others the symbol of a *black panther*, which at first was very frightening for me. In the therapy process work I was encouraged to accept, to give awareness, and to express this symbol, which at the same time was contained by my ETMT teacher. Gradually the symbol of the black panther became a rather good friend of mine, which I still carry around with me.

The AMT approach in music therapy is based on the following understanding of symbols:

> Symbols are accumulators and transformers of psychic energy. They have the relationship to ideas and actions that an iceberg has to a waterfall. Using them, the therapist is dealing with the transformation of force. Normally this can be very tricky but the music therapist has this unique lightning conductor: the tapping off of the surplus emotional dynamism through shared sound expression. It is not the psychic energy that turns to glowing cheeks, shining eyes, humming nerves through the body, and laughter, passion of tears, that is dangerous. It is the cold, frantic denial of

> emotion that causes horrible splits in the mind and leaks out into strange ideas, bodiless voices and chill moonlit inner landscapes. (Priestley 1975, p.129)

I have included my own experience of working with a symbol, because it illustrates the very core and nature of AMT with adults, which is to create a therapeutic environment where all varieties of human expression can be externalised and contained, no matter how far away they might be from ordinary social conditions or from the possibilities of being accepted by the client her- or himself.

To explore, to allow, to be aware, to express, and to experience the possibility of being contained in many forms of expression with music as the medium and through the resonating sound board of the music therapist is the rationale for providing conditions for human growth in AMT treatment.

Definitions

> Analytical Music Therapy is the name that has prevailed for the analytically-informed symbolic use of improvised music by the music therapist and client. It is used as a creative tool with which to explore the client's inner life as to provide the way forward for growth and greater self-knowledge. (Priestley 1994, p.3)

To become an analytical music therapist one has to be a qualified musician and music therapist to start with, and then undertake futher training through personal experience of individual music therapy as a parallel to analytical psychotherapy followed by ETMT in the form of Intertherapy, where methodology and self experience processes are combined. Today many music therapy training programmes have the ETMT training built into a long-term (five years full-time) training programme. (See my chapter on AMT training in this book (Chapter 11)) and (Pedersen and Scheiby 1999.)

AMT is basically music *in* therapy, but in practice it is not so clearly defined because many psychological transformations take place in the musical duets. The therapist/client relationship is in focus in all aspects of the clinical practice and all three elements – the music therapist, the music, and the client – are equally important elements in understanding and evaluating developmental processes in AMT. These include the active and reflected use of transference/countertransference issues.

To better understand what AMT is, it is important to try to define what AMT is not. Due to Priestley, AMT is not a type of music lesson in the context of looking for performance results. Such results should be looked for in the

quality of the client's life and being, and not in the improvement in the quality of her or his musical improvisation or performance, unless this is her or his considered life aim. Also, AMT is not a form of psychoanalysis using music instead of words. There are some similarities related to free association in psychoanalysis and a client in AMT opening her- or himself to a deeper extent in their musical duet. The client is invited to communicate by sharing her or his feelings, inner experiences and thoughts with the analytical music therapist after they have finished playing, however weird, shocking or shameful these may seem.

AMT is not a 'magic therapy' which will give either the therapist or the client the power to transcend all their problems without a focus in the work. The success of AMT depends very much on the knowledge, skill, warmth, power and depth of the personality of the therapist, the willingness of the client to work on him- or herself, and the rapport between them.

To become an AMT therapist is a process of learning by experiencing, which includes a process by which one has to explore one's own inner life musically with another AMT therapist, as happens in the Intertherapy training where one learns to use techniques such as splitting, holding, and so on.

The main modality in AMT is free improvisation which can be defined as follows:

> Instrumental,vocal, bodily art of expression characterised by being simultaneously created and expressed. Each improvisation will come out in some structures which can be associated with different musical styles as f.inst. atonal, jazz, rock. The different musical styles are directed by the mental functions of the performer. (Pedersen and Scheiby 1983, p.4)

Activities such as listening to music, performing precomposed music, and songwriting can also be part of AMT, but all kinds of musical activities will be subject to an evaluation of the interaction of the therapist and the client. This phenomenon is clearly stated in the introduction to *Essays of Analytical Music Therapy*:

> The feeling tone of the product of interaction seems to depend rather little on musical skills, and much more on the emotional qualities of the patient and of his ways of relating. Mary Priestley's combination of musical and verbal interaction exposes and clarifies these correlations most effectively. (Priestley 1994, Introduction)

The setting of AMT

In individual and group AMT a variety of instruments is made available in the room, such as a piano, drum kit, percussion instruments, ethnic instruments, and classical instruments (strings, woodwind and so on). The client is mainly invited to choose the instruments he or she wishes to use and the symbolic value of the choice can be a subject for investigation and reflection.

The sessions are built up through the following sequences:

- opening ritual (to be present in the 'here and now');
- opening verbal round (to focus on the topic of 'here and now', that mostly results in the creation of a playing rule);
- musical improvisation (to explore the topic in the music in dyads, or as a solo by the client, eventually followed up by painting on the musical experience);
- verbal round (to process the experiences of the musical improvisation and subsequent painting);
- closing ritual (to sum up the session's work and to build a bridge for the future work).

The sequences can be enlarged through a second musical improvisation followed by a second verbal round depending on the timing of the different parts of the session.

The opening ritual

This can be a relaxation exercise (focusing on the body) followed by a guided visualization. It can also be the exercise of finding one sound with your voice and bringing yourself into this sound by trying to forget disturbing thoughts (such as what to buy in the supermarket and so on). It can also start with listening to a short piece of music, the purpose of which is to bring the client into the 'here and now' situation.

The opening verbal discussion

The purpose of this first verbal discussion is to focus on the issue the client wants to bring to therapy, or the issue the therapist might find useful to bring up again from previous sessions. Typically the first verbal round ends up in the creation of a playing rule by the therapist, or by the client and therapist

together. Playing rules can have very different aims. Some of the most important categories (including examples) are:

- associative playing rules

  Example: Try to express your free associations of a forest at springtime;

- emotive playing rules

  Example: Try to express your fear, anger or joy, just the way you feel it here and now;

- symbolic playing rules

  Example: From a dream, imagine you are a black panther and try to express the quality and energy of this symbol;

- body-associated playing rules

  Example: Play from your stomach 'here and now', or play what your fingers want to play 'here and now';

- intra-active playing rules

  Example: Play first the energy of the 'nice little girl' and move forward during the improvisation to play the energy of the 'terrible, insensitive mother' in your description.

  This playing rule can also function where the therapist plays one of the two energy poles, which is a splitting technique;

- inter-active playing rules

  Example: Play the part of your 'inner child' which you feel less familiar with, or the part you have the greatest problems in accepting. Here the therapist can play a supportive or stable (good enough) mother-role by carefully listening, and by being accepting, which is a holding technique.

The musical improvisation

Some AMT therapists prefer to locate themselves at a main instrument (for example, the piano), which allows them possibilities to resonate the melody, rhythm, harmony, texture, dynamic, timbre and sound of the clients' music. Other AMT therapists choose, in each situation, either a doubling, or a complementary instrument to the one of the client. The voice is very useful and effective in AMT as it can intimately resonate the quality of vulnerable expres-

sions of the client. Typically the therapist will clarify her or his role in the music to the client before starting the improvisation. But the role of the therapist can also develop intuitively during the interplay, or it might change during the improvisation. It will always be a mixture of intuitively simultaneous responses to the client's music and reflected ideas based on whichever role the therapist acts out 'here and now'. Sometimes the role of the therapist is not clear until after the improvisation has finished.

Based on many years of clinical experience with AMT I have developed some guidelines for orientating myself within these free improvisation dyads. The main guidelines are based on:

1. communication theory, which is concerned with an orientation of the perception of communication 'spaces' (the private, social, and the 'soloist' space).
2. mother/infant interaction theory, which is concerned with an orientation relating to one's perception of being a 'mother with a child' in different developmental phases:
    a) a very early phase, requiring healing techniques;
    b) the phase around one to two years old, requiring holding techniques;
    c) later phases, requiring peer interplay techniques.

For further reading on these orientation tools see my chapter on psychodynamic movement in this book (Chapter 12).

Verbal discussion

In the verbal discussion following musical improvisation the client will be given a chance to reflect on and express verbally many kinds of impressions from the music being played, and the therapist will be carefully listening and resonating. Often the therapist helps to clarify what happened in the music and to relate it to the 'here and now', or to the daily life or life history of the client. The therapist can also interpret what he or she has heard in the music if it is not addressed verbally by the client. An example could be: 'I heard very much sorrow in the music. I wonder if you can identify with this feeling as it hasn't been expressed in words between us up until now.'

An AMT therapist is trained to verbalise sensitively according to the process taking place and a very important issue in the verbal training of the therapist is to make sure the therapist sustains an empathic connection with the

client both in the supportive parts of the verbalisation but also in the more confronting parts.

Closing ritual

A closing ritual can be very short but it is also very important in the process. The aim of the ritual is to sum up the work of the session (for example, telling the client to close her or his eyes and let the session pass by and try to keep in mind what was important and to let go of the rest). If the process cannot be summed up because of an incomplete process of work on the issue, the closing ritual aims at linking the awareness of the important elements of the process 'here and now' to the next session.

Referral criteria

AMT can be used for a variety of client populations and is developed both with adults and children. The use of countertransference and interpretation differs within these areas.

With adult clients one main issue in the phase of making a decision whether or not to start a therapeutic process in AMT (individually or in groups) depends fundamentally on the client's motivation to use music as the medium of therapy, and the quality of the relationship that can be built up between the therapist and the client. Some guidelines for contra-indications for AMT are (summarised from Priestley 1994, pp.13–14):

- clients with profound hearing impairment;
- clients with an IQ below 80 (AMT can be used here only when combined with the specialized knowledge and experience of the therapist);
- overtly psychotic clients who are experiencing a world of dreams, hallucinations and delusions (they are already living symbolically, which precludes the conscious understanding of symbols – AMT can only be used here in a moderated form and when combined with specialised knowledge and experience of the therapist);
- the split kind of psychopathic clients, who must be treated cautiously.

Overall, concerning clients who agree to work with music, the following guidelines for referral criteria identified from clinical practice experience can be defined as:

1. clients who over-intellectualize and at the same time have a poor connection with feelings. In these cases AMT may provide a better bridge between thoughts and feelings because the improvised language of music is very close to the language of feelings. The clients can stay within their split personality during the period of exploring how they can be connected to and express unfamiliar feelings in order better to integrate feelings and their intellect. (See case study on p.81)
2. clients who are generally very withdrawn in their relationship to others. AMT can allow a possibility for expressing oneself simultaneously with another person and still have the feeling of not really being connected – experiments can take place with the perception of closeness and distance, and a 'connectedness' can develop in a tempo that can be accepted.
3. clients who suffer from severe anxiety (phobic anxiety, death anxiety, social anxiety). AMT can provide a sensory perception of an inner anchor (a melody, a rhythm) which can be a safe place when 'the ground disappears', and the function of which can be to stabilize the feeling of disappearing, dissociation, or chaos).
4. clients with boundary problems (too loose or too tight) and with a poor feeling of being centred or grounded. AMT can provide a sensory perception of a centre-point, which can gradually stabilize body sensations and a feeling of trust in their own identity.
5. clients who suffer from low self esteem and poor identity. AMT can provide new possibilities of exploring bodily perceived self-expressions such as being big/small, being strong/weak, repeating and recognizing sound symbols as a mirror of personal strength. (See case study on p.79)
6. clients who suffer from inhibiting obsessive and compulsive actions, thoughts or rituals. AMT can offer an expressive channel in a language characterized by a strong, inbuilt, seductive flow, a flow which can gradually and carefully open up a more flexible way of perceiving, being and acting.
7. clients with communication or performance problems (stuttering, performance anxiety). AMT can offer a medium for expressing

oneself without being exactly evaluated, as one can play within the concept of free improvisation and paradoxically use the medium which very often causes the most severe performance anxiety gradually to resolve this problem.

8. clients suffering from depression or bipolar manic depression. AMT can give the depressed client a possibility of being active, communicative and interactive in a depressed state of being without feeling the pressure of having artificially to raise her or his energy. In an intermediate state of being, neither totally awake nor asleep, one can still be connected to a partner in the music, and be creative.

Several more pathological symptoms could be mentioned but I have tried to select symptoms which emerge as part of many different diagnoses. I have also tried to select a variety of symptoms which show the spectrum of possibilities of clinical applications of AMT.

The overall criteria for starting an AMT is a process where the client accepts the use of music as part of the therapeutic concept, and where it is possible to build up and develop a stable alliance between the therapist and client.

As mentioned in the guidelines for contra-indications, some clients need specialised knowledge from the therapist. Many AMT therapists today have developed specialised knowledge from clinical practice to offer AMT to overtly psychotic clients, who are experiencing a world of dreams, hallucinations and delusions and who show a minimum of interest in playing music. AMT can provide a link where one can follow the client at a sensory level in her or his expression of a deluded or distorted world without the client being automatically required to try to enter the 'so-called' normal world. Through containment and reverie techniques, combined with very sensitive listening attitudes by the music therapist, the client can very gradually develop enough trust to open up and move away from total isolation. (De Backer 1997; Jensen 1999; Pedersen 1997, 1998, 1999)

Concerning AMT work with overtly psychotic clients, I have developed a modality within AMT called a 'Holding and Reorganising Music Therapy Modality' which is both supportive, confronting, and also works consciously on developing an alliance that is stable enough to motivate the client for further self-exploration. (Pedersen 1999)

Clinical application of AMT

As referral criterias and clinical applications are strongly connected I want to follow descriptions of referral criteria by quoting summaries of clinical application as they are described by Priestley (1994):

- to decode personal messages and symbolic elements of dreams;
- to reduce the client's resistance to denied or split-off emotions as it can lower the threshold of consciousness (allow emotions to be experienced symbolically in sound or movement and therefore a little less painfully – often bringing vivid memories and inner images);
- to externalise aggressive and auto-aggressive tendencies (infantile anger) in sound without the therapist succumbing to the assault;
- to let the healthy parts of a client come to work with such 'mad' parts as: dissociated impulses or perceptions; groundless fears; bodily symptoms; or rigid defensive structures. (To questioning considerations of clients as 'wholly mad' which would prohibit their sane and healthy parts being able to help their 'mad' parts.)

Methods used in AMT

Tools of countertransference

The methods used in AMT with adults are closely connected to the function of the therapist. The therapist relates to the client through an internal ('inner way') of intuition, and through external perception with ears, eyes and cognitive reflections. The inner way is called countertransference and in dealing with this phenomenon the therapist's function is twofold:

- he or she will contain the emotion of the client with his/her musical expression, matching her or his honest moods (these parts of the phenomenon of countertransference are also called 'reverie' or 'attunement' (Stern 1985);
- to deal with countertransference as it is understood in AMT the therapist must also be alert to the inner voice of the client's unconscious, and sometimes musically reproduce these feelings from the client's unconscious.

According to Priestley (1994), countertransference is a useful tool for exploring the client's hidden emotions, and it is made more reliable if therapists have themselves previously gone through the process of analysis (or a long-term individual AMT). In Chapter 11 it is suggested that a long-term individual AMT process should be followed by Intertherapy training.

In recent years several experienced music therapists have tried to describe how they identify countertransference phenomena by analysing recorded clinical improvisations. The most important papers have been written by Scheiby (1998) and Streeter (1999). Priestley, as the music therapist who pioneered AMT, has defined three different 'tools' in the phenomenon of countertransference:

1. Countertransference – the therapist's own transference distortions in her or his relationship to the client.
2. E-countertransference, also called emphatic countertransference of concordant identifications
3. C-countertransference, also called complementary identification.

The first tool was proposed by Priestley within the framework of the Freudian definition of countertransference. The second tool, e-countertransference, was inspired by Racker, Heimann and Bion, and is summarised as follows:

> Concordant identification is those psychological issues that arise in the therapist by reason of the empathy achieved with the client, that really reflect and reproduce the latter's psychological issues: the analyst's total response to the client's needs to have the resonance of the exterior to the interior – a plucked string instrument (the client) whose music resonates on its sympathetic strings (the therapist) …
>
> …The therapist may find that either gradually as he or she works, or with a suddenness that alarms him or her, he or she becomes aware of the sympathetic resonance of some of the patient's feelings through his or her own emotional and/or somatic awareness. Often these are repressed emotions that are not yet available to the patient's conscious awareness but they can also be feelings which are in the process of becoming conscious, in which case they may be very dynamic and fluent in the therapist, especially when he or she is improvising…
>
> …The therapist's e-countertransference depends on his sensitivity and his freedom to experience the incoming emotions. But his ability to formulate

> it consciously and use it to the benefit of his patient depends on his clarity of thinking. (Priestley 1994, pp.87–90)

The third tool, c-countertransference, is defined, in summary, by Priestley as follows:

> A complementary identification caused by the therapist identifying with the patient's internal objects which he or she has projected on to him or her or where he or she introjects the patient's introject and is taken over by it. It is an unconscious process. The situation is a repetition of the patient's past, not that of the therapist's past, as in the definition of counter-transference by Freud.
>
> There seems to be a relationship between e-countertransference and c-countertransference in that the less the therapist is aware of e-countertransference, the more likely he or she is to be taken over by the c-countertransference.
>
> There is, with c-countertransference, the feeling of the therapist being diminished, of a dwindling of his powers or freedom, insight and emotional breadth. (Priestley 1994, p.85)

Priestley is aware that those tools of the phenomenon of countertransference are linked with subjective elements such as experience, sensitivity, awareness and emotional freedom by the therapist and as such not easy to research in a reliable way. On the other hand she is also aware that the tools are present in, and part of, all therapeutic work – one may or may not give them attention in evaluating the therapeutic process.

She tries to find a solution, like many other analysts, to describe the phenomena through the help of images, and she sums up her definitions in the following way:

> …awareness is at the core of all forms of countertransference, and if creating an image helps the therapist to focus it then he should not hesitate to do so. Clothed in such hygienic analytic terms, these experiences sound quite pat and manageable – in reality they can be extremely spooky to the uninitiated therapist experiencing them for the first time. (Priestley 1994, p.87)

I myself have tried to define the tools of c- and e-countertransference through the use of my own terms such as 'Listening Attitudes' and 'Listening Perspectives', as I think that these terms are more connected to musical improvisation

than those terms drawn from psychoanalysis and verbal psychotherapy. (Pedersen 1997, 1999)

These 'Listening Terms' do not simplify the definitions and I personally think Priestley has very clearly, and in a flourishing language, given future music therapists a deep understanding of those important tools in music therapy. These tools are defined and also used in other music therapy approaches, but AMT is very much based on the knowledge and use of these tools.

Structure of the music

In AMT, as developed by Priestley (1994), no structure of musical form is used or imposed from an external source in improvisation. When improvisations fall into known musical forms (particulary ternary form (ABA) and, less often, binary form (AB)) they have just been a natural expression of the inner need for this kind of balance to contain the player's expression.

The musical structure as regards rhythm and pitch (less so timbre and dynamics which are more responsive to the mood of the moment) is governed by the mental state or function that rules the client's psyche at the time.

Priestley has been using what she calls the structure of thought (a given scale, a given rhythmical pattern, and so on), only for the purpose of letting this structure partly take the place of a superego function, and thus letting the scale or mode almost take the place of a repression of the emotions not approved by the superego. It is as if the superego approves of a set task, such as playing in a certain scale of mode, and when this is done a repression is slightly lifted to allow some expression of a formerly intolerable emotion to surface in the patient's mind during the improvisation, with or without it being expressed in the music (when working with repressed emotions).

She also emphasizes that the musical structure in the improvised duet may change considerably as the client develops, or the musical structure may remain the same but the content of psychological experiences while playing will become deeper.

This last statement is somewhat controversial due to the fact that many AMT therapists have made inquiries in qualitative research concerning correlations between curing developmental symptoms found or stated by the client and defined progressions in the musical improvisational material. (Austin 1999; Frederiksen 1999; Jensen 1999; Langenberg 1999; Metzner 1999; Pedersen 1997, 1999) It is still a core and relevant question to research whether such a correlation always exists, and, if not, whether one can define

areas or client populations where the prognosis for such a correlation seems to be negative. I think it is important to remain open to both possibilities and realise that music therapists might need to use very different evaluation tools in the one or other case.

Priestley tends to use atonal dissonances when she feels the patient is strong enough to be stimulated to bring out her or his emotion more forcefully, and to use tonal harmonies where she feels that there is a need to contain emotion in a reassuring way, or to help a fragile patient tolerate just a little emotion. This however does not take into account working with the client's transference, which might demand that one plays tonal sadness, or atonal madness, at a certain time in order to make a client, who is ready for it, aware of the hidden layer in herself.

To sum up the structure of the music in AMT, I want to quote Priestley as follows:

> …some of the richest phantasies have been experienced using the structure of a very regular rhythm; some of the wildest music has been produced using the structure of a prescribed thought or idea: some of the most elusive repressed emotion has seeped out using the structure of a difficult scale. (Priestley 1994, p.133)

Case studies

Case study 1

I will illustrate an example of point 5 of the referral criteria (see p.73) with a case example from my own practice:

> A man in his thirties came to music therapy as a private client for the purpose of self-development, and was not referring himself for any psychopathological reasons. He described his symptoms as an experience of being split off in at least two different parts of his personality:
>
> - a nice little boy who always obeyed any authority without reflection and who felt himself as too easy going in relationship to others;
> - a demonic part, the energy of which frightened him and gave him psychosomatic symptoms, such as either a feeling of a total gap in the neck area or a feeling of fire in the same area ('as if all my energy is sometimes drawn out of the body through my neck').

The body symptoms frightened him a lot and he felt out of control.

Using the splitting techniques of AMT we started to explore together the quality and energy of both the nice little boy part and the demonic part. Musically the nice little boy part was expressed mostly through playing scales up and down the piano (as if exercising for piano lessons without any dynamic element in the music). The demonic part was expressed through very dark clusters in the lower part of the piano and as the client gradually felt more comfortable about this violent energy he also dared to express it through his voice (by primitive screaming sounds).

For some weeks we explored the two different qualities and the client became more familiar with both of them, but he still could not develop any kind of dialogue between them. One day I suggested a playing rule – 'Allow yourself to be abnormal' – as I knew the client identified the split personality as being normal for him.

The client played again the two different parts with piano and voice and I supported and facilitated him so the demonic part was expressed at a very loud (fortissimo) dynamic level. Because he remembered the playing rule, the client continued, after having expressed the demonic energy, where he would normally stop playing. He explored other instruments than piano and voice, continuing on a metallophone, and on a gong. He allowed some quite chaotic sounding landscapes to be his transitional music to get to the hand drum, which he grabbed by accident and started off playing in a clear steady beat, sounding very much like an Eskimo Shaman drum player. I immediately followed him by accompanying him with a shamanic voice quality and he himself started using his voice with this sound quality. We developed together and were resonating with each other in this shamanistic way of singing, the client accompanying our vocal sounds with a quick stable pulse on the hand drum.

After finishing the musical improvisation, the client was very surprised about the feeling of energy and strength in the musical expression, and in his body. He had never identified with being a strong personality. He realised that the energy he was afraid of was also an enormous strength he could integrate in this kind of musical expression. This recognisable form of shamanistic drumming and singing could be tolerated by his nice little boy part and his need for aesthetic expression.

We continued working with shamanistic singing and drumming, and through this music style he could gradually internalise the demonic energy as being a strong part of his personality.

Today this former client has graduated as a music therapist and he has an enormous capacity of being a resonating sound board for clients with complex psychological problems.

Case study 2

An example of point 1 of the referral criteria (see p.73) can be illustrated with a case from my clinical practice. In this example the client was a psychiatric client diagnosed as having disorders in personality structure including severe anhedonic features, and with rigid intellectualising in his communication with others. According to ICD 10 (International Classifications of Disturbances, 10th Edition, edited by the World Health Organisation 1993) he was classified as F.60.8, other specific personality disturbances:

He himself further defined his problems as being afraid of relating to others, especially women, so I thought he was rather brave to accept starting a music therapy treatment with a woman almost his own age. He refused the offer of supplemental medical treatment, and he came to music therapy as an out-patient once a week for 57 weeks altogether. He had no other treatment offers during this time.

His history can briefly be summarised. He was born very soon after a sister who died at the age of two weeks. He described his mother as over-protective and dependant and his father as rather violent and an alcoholic. His father committed suicide two years before the client started therapy. He had been in hospital for six weeks by the age of 18 months suffering from anorexia, and in this period he was, due to hospital customs at that time, not allowed to see his parents. He could hardly recognise them after the hospital stay and he more or less refused any intimate contact with them after this time. He has finished three different forms of education (according to him out of guilt feelings to satisfy his mother who gave up her own education to take care of him when he was a sick child). He knew all the time that he would not be able to work within any of these working areas (a social pedagogue, a teacher, and a mathematician) as he couldn't cooperate with others in daily working situations.

In the first session he was told just to explore sounds on a self-chosen instrument and to try to allow himself to play just one sound – to listen carefully to it and to let the sound bring him to the next sound. This playing rule was suggested in order to help him resist his rigid way of always trying to imagine what a sound should sound like before he made it, which again gave him the possibility of devaluating each sound as 'wrong'. Also this instruction gave him the possibility of being present in the sound and in a musical relationship in the 'here and now'.

He started off playing the piano with alternately dark and light sounds at a slow tempo, and as I perceived and understood his music, he seemed to be rather involved in listening to his own sounds. I played the second piano in a complementary way, using the structure of a repeated heart beat rhythm in the middle of the piano as a centre-point, as he seemed to be rather polarised in his playing. We played for 18 minutes.

After the first improvisation he sat for some time in silence and then said: 'I have no words'. I felt this statement was a positive prognosis considering he suffered from a symptom of rigidly intellectualising. He was not really aware of me playing but he had had a perception of some kind of centre, and he said: 'I need a centre-point from outside, as I don't feel centred myself at all.'

During the first months we played together in roles where he explored sounds which at times provoked him to acting out violently on the drum kit, while I kept the centre-point in the dynamic level of the musical interaction.

He gradually felt more comfortable in acting out and in being primitive in his musical expression. One day he came and talked about a dream which became a milestone in the futher symbolic work of AMT. In the dream he was running on a frozen lake and had to climb a fence of barbed wire. After this he could see a fossilized sea urchin under the frozen surface of the ice, which he identified as a frozen part of himself – a part of himself which made him always feel like an audience to reality.

I suggested he tried vocalising to explore this fossilized sea urchin with his voice, which he agreed to do. I shared with him, through my voice, the quality of this fossilized animal, and I experienced the quality of my voice as being extremely insecure, icy, very naked, of a very fragile nature, a high pitched quality, and at a very soft *(pianissimo)* dynamic level.

Gradually through the improvisation the voices grew in sound volume and created more vibrations and sound waves together, which I understood as both an attempt to break the ice in the symbolic world, and also as performers becoming more and more present and related within the physical world.

I was almost overwhelmed by insecurity. This improvisation reminded him very clearly of the fossilized sea urchin and he was obviously very touched by the situation. It opened up a third phase in the process – a phase where he had lots of dreams and nightmares and where he brought a pile of water colour paintings to the music therapy sessions (paintings he made himself in between the sessions and wanted to share with me). Among other dream symbols he also brought the symbol of the black panther which made me feel very connected to parts of his unconscious life. I didn't tell him, but it surely influenced our joint improvisations. His voice quality developed and he connected to a very deep and colourful voice quality (the bass quality which he had never expressed).

In his drawings he illustrated the inner fights taking place during the phase of the fossilized sea urchin melting – then becoming a human face – and this face gradually coming above the water line and seeing lots of frightening demons, such as snakes and devils. He also had dreams of waterfalls overwhelming him, but he succeeded in being in contact with, expressing, and sharing feelings of extreme anxiety, to the extent that he could gradually transform it.

In his last two water colour paintings the first one showed a beautiful man and a beatiful woman together, and he told me that he now had a feeling of having better integrated the female parts of himself. The last painting showed a younger man – much more vulnerable but better integrated. He chose the date to finish his therapy himself.

In our final joint improvisation we both played the piano and used our voices. The music had a free flowing quality and I could totally let go of the role of being a centre-point and play with him as I would play with a friend or a colleague.

As the client allowed me to use our material for education and research, and as I was asked to write an article for a medical journal three years after finishing this case, I asked him to write a client report. I would like to quote a little part of this

report as it shows how music therapy can be effective not only in the therapy process but also in the everyday life of the client for some years afterwards:

> More than three years have passed since the music therapy stopped: things have happened. I feel like having partly changed and still part of me is the same. But I have a clear feeling of being able to 'fill up' myself much better than before the music therapy.
>
> Earlier I often felt like a sad, lonely and misunderstood 'steppe wolf' sitting in a waiting room, and when I was with other people I felt like a spy coming in from the cold. I am still a 'steppe wolf' but now a far more free, unpredictable, and amused acting one. Instead of being tacit and speculating, I am now a wolf who enjoys howling with others. I am much better at taking care of myself and I am not that scared of hurting other people.
>
> My former morning crises – crises which could last for the whole day – where I felt as if a catastrophe was waiting just around the corner, have almost disappeared. Even if the music therapy sessions are officially ended, I feel as if it is still working in me. All the experiments, sounds and motifs I created in the music I am now using in interaction with other people and this gives me a greater feeling of freedom – freedom that can be understood as me having many more strings to play on – many more possibilities of handling different situations in my life. I still make sound improvisation with my voice just to sense how I feel deep inside myself. This gives me a useful tool to loosen up psychological knots and tensions that come up. (Pedersen 1999, p.16)

Conclusion and outcome of AMT

AMT has had an enormous influence on the practice of music therapy in mental health and in counselling work. It is subject to continuous development as a method, and futher modalities connected to specific client populations have developed. But the use of transference issues as core tools, and musical improvisation as a symbolic channel for human expression, is still the basic platform of this approach.

I have mentioned quite a few AMT therapists from later generations who have tried to define and describe those basic elements from recorded material. This can, I hope, give more valuable knowledge to what is actually going on in the musical dyads.

Parallel to this there have been some evaluations based on patients' reports (questionnaires, essays, and so on) which can provide evidence of the lasting effect of AMT.

In my own practice in mental health I have, together with my colleagues, collected data through a questionnaire given to patients after termination of individual music therapy (18 clients having finished therapy over a period of 3 months to 3 years from the time of inquiry). The questions concerned the following areas:

1. The patient's experience of the relationship with the music therapist.
2. The patient's experience of music as a useful tool in treatment.
3. The patient's experience of coherence between musical and verbal parts of the treatment process.
4. The patient's experience of the outcome of music therapy treatment.

Overall, positive reports were received for areas 1 and 4 (a four-level scale was used from very bad to very good). In area 2, 80 per cent reported positively and 20 per cent negatively. Reasons given for the negative answers included that the patients didn't totally overcome their fear of performance, which for us was important information. Sixty per cent of the patients stated that the outcome had lasted over time and was now integrated in their current life.

These evaluations can only give a modest idea of the value of AMT as the numbers of subjects involved are very small.

Having read most of the literature on AMT as formulated by Priestley, and futher developed by the next generation of music therapists orienting their work on AMT, I want to close this article by stating the documented evidence of AMT:

- freer self-expression and a feeling of balance in its use;
- increased self-respect;
- a more focused sense of purpose in clients' lives;
- diminution or greater toleration of psychosomatic symptoms;
- quicker recovery from emotional disturbances;
- increase in adventurousness;
- more satisfying relationships;
- some increase in energy for life.

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CHAPTER 6

The Sound of Silence – The Use of Analytical Music Therapy Techniques with a Nonverbal Client

Juliane Kowski

History

Anna is a 35-year-old woman diagnosed with profound mental retardation caused by unknown prenatal influences. Her mother institutionalized her when she was three years old, where she remained until age 14. As of autumn 1996 I have been her music therapist in a residential setting where she has lived since 1978. She has no relationship with her family, is nonverbal, does not participate much in group activities, and avoids social contact.

When I met Anna she was lying in her bed hiding under a blanket. She would neither look at me nor leave her bed. With the hope of getting her out of bed I began sessions by singing and playing guitar at her bedside. After a few weeks she got out of bed and smiled at me, picked up a drum and immediately accompanied my music with a strong sense of rhythm.

In the beginning, sessions lasted about 10 minutes, but ended up lasting from 30 to 45 minutes. After trust had been established I coaxed Anna out of her room, fetching her and singing ' Hello', singing as we descended two flights into the music therapy room. Eventually she was even able to participate in a threesome. Anna continues to have days when she isolates herself under her bed covers but these days have become rare.

My music therapy goals were to draw Anna out of her self-imposed isolation, to provide her with experiences of more satisfying relationships, to increase her life energy, and to give her tools and means for expressing herself fully.

I would like to provide you with an example of a typical musical interaction within a session. This moment took place after two and a half years of treatment and demonstrates how I use Analytical Music Therapy techniques in work with nonverbal clients. After listing the four different phases of communication, I will provide a short analysis and offer some interpretations and conclusions. This example proves that Anna is able to communicate on a more sophisticated level than one would have previously believed possible given her low IQ (25–30) and inability to use verbal language. She is capable of rhythmic call and response, remains always within the time, chooses to speed or build up the music with intention, and plays steady notes on the piano that fit within my harmonies. These are important facts that point to potential which the staff and aids who have daily contact with Anna should know about. She should have the opportunity to translate what she learns through music therapy into other relationships, an opportunity to gain more widespread community acceptance.

This example shows four different phases of communication between Anna and myself:

1. Phase: 50 seconds;

   Establishing the musical dialogue;

2. Phase: 70 seconds;

   Entering an intimate space;

3. Phase: 1 minute 40 seconds;

   Holding, musical mothering;

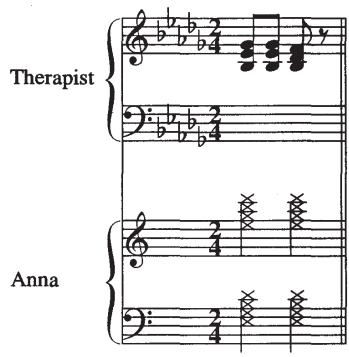
4. Phase: 1 minute 25 seconds;

   Separation – leaving the intimate space.

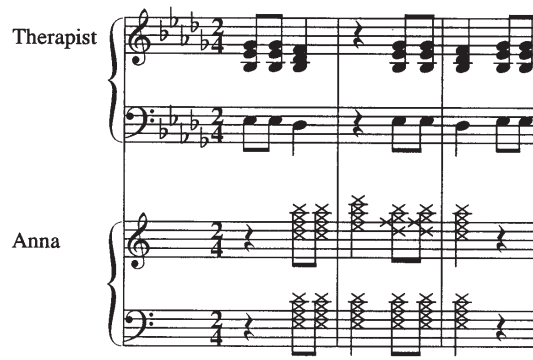
This session took place in February 1999 after two years of treatment. We play keyboard, Anna choosing the higher keys, I the lower keys. We are coming from a playing/singing dialogue where I encourage Anna to express herself in the music.

1. Establishing a musical dialogue

I provide simple harmonic and rhythmic structure, repeatedly playing G flat/A flat – providing a safe, predictable musical container.



Transcrption 1

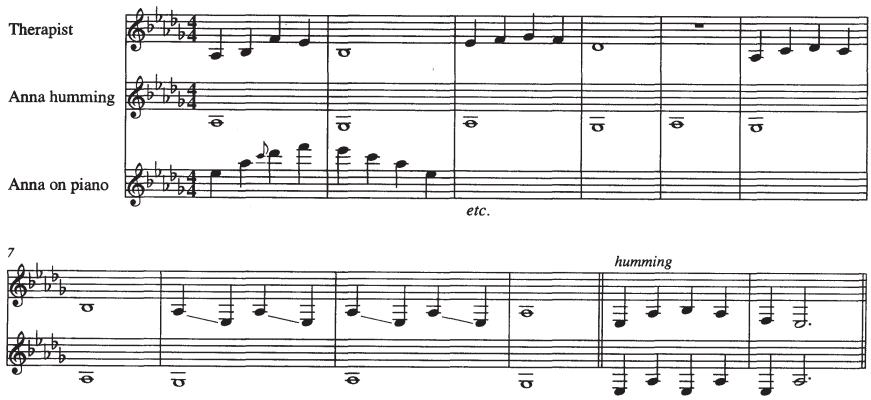


Transcription 2

Anna reacts strongly, playing quarter notes in clusters at first (see Transcription 1), sometimes picking up rhythmic patterns, but leaving enough space for responses so that it appears to be a real musical dialogue (2). Her playing gets more intense, louder, with more velocity, and a slight tempo change. I observe tension in her facial and bodily expression. I react by matching her tempo, playing clusters, moving on to the higher keys. There is a noticeable build-up in the music and then Anna suddenly stops.

2. Entering an intimate space

Anna initiates a much softer mood, playing single notes on the piano. I respond by reflecting her musical expression, playing and singing simple melodic lines that encourage vocal expression (in the key of G flat major, A flat major matching her vocal range). Anna hums and groans around A and G flat, often sliding up and down within a fourth (E flat – A flat – E flat) (3).

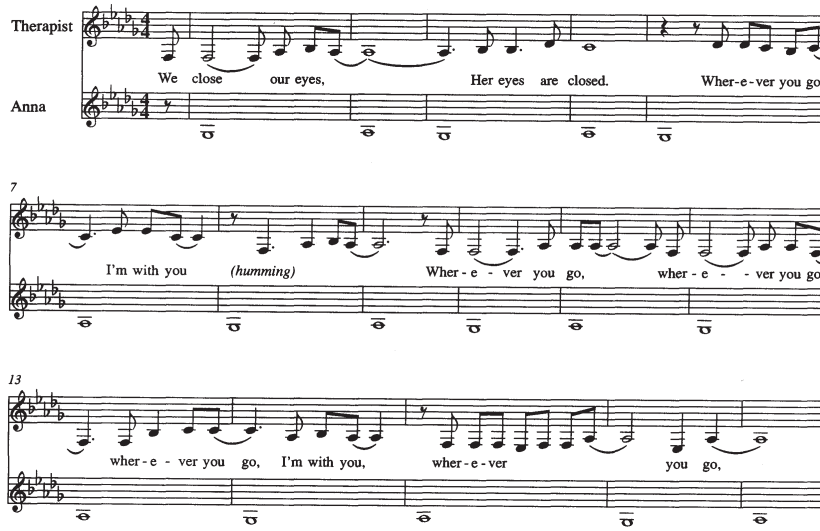


Transcription 3

I sing in a similar sliding fashion (reflecting) to meet Anna within her expression, which always sounds to me like a sad wailing. She often accompanies this way of singing with a slow rocking motion that evokes for me the image of a little child, alone and comforting herself. Anna plays single notes on the piano, perfectly fitting into the harmonic structure as well as the 4/4 time frame. I understand and interpret this as a further development of our contact. Anna closes her eyes.

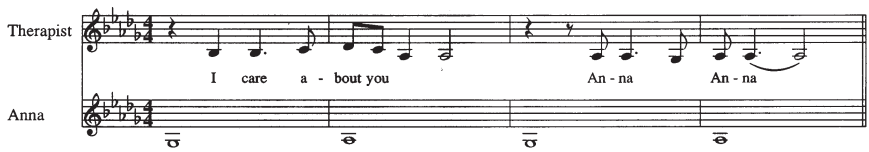
3. Holding, musical mothering

I sing a reflection of what Anna expresses musically and bodily. I offer support, mothering and holding, giving words to feelings (4).



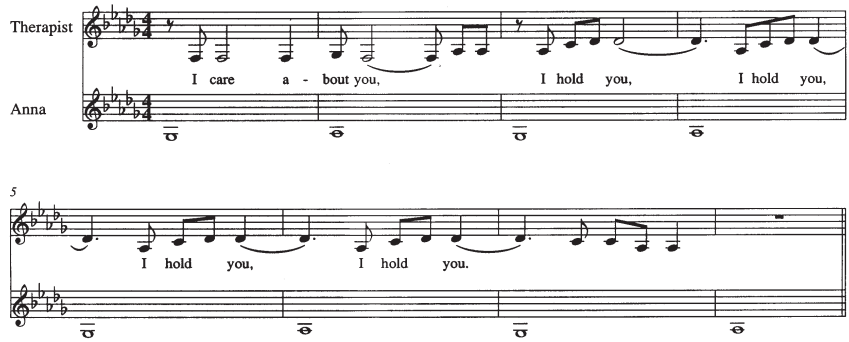
Transcription 4

'Wherever you go I'm with you.' Here I work with my countertransference, reacting to the quality of her music, body and sound expression. I am the channel for Anna's feelings, knowing from my own experiences what it feels like to be alone and how important it is to be assured that somebody is always there.



Transcription 5

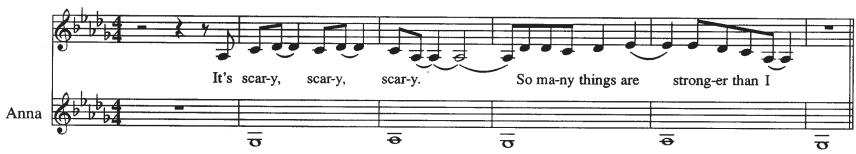
I structure the musical holding by repeating the same harmonies as before (symbolizing stability), while singing a somewhat repetitive melody within Anna's vocal range. Anna hums and wails around B flat/A flat. I feel that Anna is completely absorbed in the music, her eyes still closed.



Transcription 6

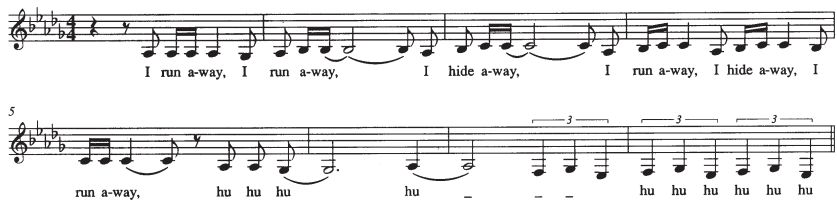
I sing 'I care for you' and receive a subtle but stronger response. Anna is wailing around B flat/A flat/B. With the lines 'I hold you' (6) this wailing swells up even more. I repeat this line. Anna reacts with increasing volume and tempo on the piano. I interpret this to mean that Anna would like to run away because the intensity of the emotional contact is becoming too strong for her and she wants out.

4. Separation – Leaving the intimate space



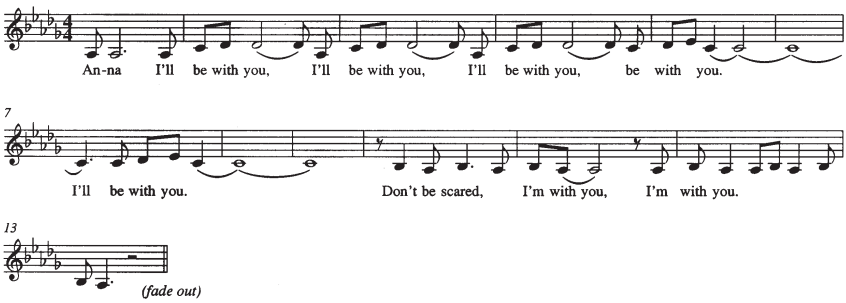
Transcription 7

I sing 'It's scary', interpreting and acknowledging Anna's musical responses and trying to give her permission for her feelings, encouraging her to express and accept them, still offering her more holding/mothering (7). Anna plays strong clusters and speeds up as well.



Transcription 8

I sing about her running away, hiding away (thinking about how she used to hide in her room under her blanket), reflecting her tempo change (8). I reassure her again that I am with her, repeating this line with the same melody many times (9).



Transcription 9

Interpretations and conclusions

Despite the fact that Anna's IQ of 25–30 is below the threshold of 80 that Priestley (1994) thought suitable I use her techniques because my experiences have proved that people are sometimes able to communicate musically at a deep preverbal level, and that this musical mode of communication can provide them with an important means for expression.

This musical example shows that Anna needs the mothering and holding that she has been deprived of throughout her life. Over the course of these three years a certain trust has developed between us and she is now able to be with me in a very intimate relationship. Although she might have been capable

of such a relationship in the past she has been hurt so many times that she is fearful. As a result she has been left completely on her own; isolation is what she knows and is afraid to let go of. Unfortunately however, she cannot tolerate the intense emotional experience of a relationship like that of mother and child for too long and 'runs' away, which is expressed musically by tempo change and strong wailing.

I found a few AMT techniques very useful. One of the techniques I have been using in almost every session with Anna is called 'Sub-verbal communication' (Priestley 1994). We play music without a theme and Anna determines the direction.

Priestley's (1994) 'holding' method has been essential in our work. Anna enjoyed being held musically, and sometimes even physically. I translated the holding vocally by using the framework of the 'vocal holding technique', one of the techniques developed by Diana Austin described in *The Dynamics of Music Psychotherapy* (Bruscia 1998). The repetition of two harmonies creates a stable, predictable musical environment for vocal improvisation and expression. Austin (1998) described the repetition and rocking motion of the two chords as providing a base for regression. I use an adapted form of Austin's technique 'free associative singing' (Austin 1998) in which I sing about what I receive musically, bodily, and vocally from Anna. Here I work upon my countertransference, transforming it into meaningful musical contact. Using transference and countertransference as AMT tools is a big advantage in work with nonverbal clients. The transference in our relationship has been always a mother–child relationship. In this relationship I see Anna as a two-year-old child, deprived, who runs away and comes back, which is musically expressed by getting into contact with me, remaining in a relatively intimate contact for some time, and then separating again.

At this point I would like to use a definition of countertransference once articulated by Benedikte Scheiby (1998) since it is the essential and most difficult medium to work with:

> Musical countertransference consists of the sound patterns that reflect or evoke feelings, thoughts, images, attitudes, opinions and physical reactions originating in and generated by the music therapist, as unconscious or preconscious reactions to the client and his or her transference. The medium through which these are conveyed is the music played in the session. (Scheiby 1998, p.214)

What kind of countertransference is encountered?

First of all I need to say that I think using countertransference is definitively a positive aspect of this work even though it requires constant awareness, self-observation and close supervision.

Anna touches upon my own personal experiences. My mother wasn't always there when I needed her the most. Feeling alone and isolated are feelings I know. By allowing myself to be open, by functioning as a receptacle for Anna's feelings, I am verbalizing what she is unable and afraid to express. The music and I are channels for communication. I use countertransference as a tool of communication. I also use vocal cues from Anna. Very subtle vocal expressions of hers resonate within me and lead to more communication. There are moments in the music when my awareness of countertransference leads to self-critical thoughts about my own reactions. For example, at the beginning of phase two, after a pause, Anna initiates a different type of music and I jump in very quickly, taking her cue further, following my own need for deeper communication. When thinking about it afterwards I thought I should have left her more time clearly to express her direction musically. On the other hand she might have needed that little push.

'Reflecting' (Priestley 1994) is one of the most important techniques that I have been using. Anna hid in her bed all the time and it seems clear that there is a need to be seen, heard, and accepted. Anna needs a restorative experience in which she can emerge with a consistent, symbolic 'mother'. Here is yet another countertransference I work with. I am a mother myself, with a very young child, and I want to be a 'good mother'. Anna constantly evokes my feelings with regard to my own personal struggle to be able to be the holding and loving mother I wish to be.

Countertransference is one of the most important therapeutic tools in the AMT approach, and needless to say one of the most challenging as well.

Why AMT?

I go to my own music therapy supervision–training where I have been working on personal issues in a nonverbal and purely musical way, and therefore using the AMT approach with a nonverbal client did not seem foreign to me.

At first I offered songs and more musical structure but Anna did not respond well. She seemed to want more freedom. Through her I learned how AMT techniques work on a deeper level to reach her in her isolation, and provide her with a place of healing and trust. AMT is not the only technique I use with this population. I see other clients who need much more structure and

repetition in order to feel safe and to be able to express themselves. With these clients I mainly use songs for growth and change.

What did the work with Anna give me?

Anna showed me how powerful music can be. She made me completely forget that she has been labelled with 'mental retardation' by showing me how to meet her musically, on a very primal, pure and human basis.

Most of all she gave me a lot of love, something she herself has been deprived of, and I am very grateful for having met her. Unfortunately, in May of 1999 I had to change my work place for personal reasons, and as a consequence I had to transfer Anna to another music therapist.

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Chapter 7

The Psychodynamic Function of Music in Analytical Music Therapy with Children

Wolfgang Mahns

Introduction

Existing disabilities in children can be enhanced at school, and the child can suffer for many different reasons. In some cases, because of traumatic and neuroticizing childhood experiences, some children are not prepared for the size of the group. In other cases, learning conditions, as well as the class and school atmosphere, can play a part. These difficulties can show up in the form of *elective mutism*, uncontrolled actions on impulse, *slow learning*, exaggerated adaptability, and *speech problems*, as well as *behavioural disturbances* or *learning problems*.

Within the scope of a large city-wide project in Hamburg, called 'Integrative *Grundschule' (Integrative Primary School* – classes 0 (pre-school) to class 4), I am working as a special pedagogue and music therapist with children aged five to ten years old. My main opportunities lie in the following four areas:

- individual music therapy (10 to 50 sessions);
- music therapy in group work (10 to 20 sessions);
- integrative stimulation of speech (including breathing exercises, voice and body awareness);
- talking sessions and consulting (1–3 sessions).

My theoretical and methodical background is Analytical Music Therapy (AMT), as developed by Priestley (1982, 1983) and Eschen (1980), which I have applied to my work with children. Approaches from analytical child therapy (Winnicott 1971) inspired me in regard to analytical understanding. The clinical improvisation in the work of Nordoff and Robbins (1977) and the

work of the great German *improvisation* teacher Friedemann (1973) were inspirational concerning musical and creative activities and reflections about their chances.

Definition

AMT with school children is useful with those children whose difficulties manifest themselves as emotional, behavioural or physical disturbances with a negative effect on learning, social contacts, and development in school. In *improvising* music and in talking, and sometimes adding other methods of symbolical expression like drawing, playing with puppets or cooking, I am trying to enhance their ability to express their difficulties. I try to understand the psychodynamic of all activities in terms of *transference* and *countertransference*, which is expressed *pre-symbolically* and *symbolically*. From here I try to support personal development in expressiveness and the understanding of what is 'behind the curtain' of symptoms or inadequate interaction. Goals are – among others – more inner freedom, and more effective coping with reality (cf. Mahns 1996b).

Setting

My *music therapy room* is part of the school. There are different levels of playing and instruments: a piano in the centre of the room; the interior of an old untuned piano at one wall; a set of bass xylophones, drums, cymbals and chime-bars; and a few smaller instruments such as mouth organs, small bars, drums and an Autoharp on a blanket. On a table there is a tape recorder. This is also the 'talking place', should need be.

To begin with I talk with teachers and parents. Then, during a 'first- interview', I try to find out where the child's strengths and weaknesses are. First musical contacts and a projective test round the first contact off. In the improvisations I partner the child, going with her or him, accompanying, showing another side. We create a common 'product', which indicates the limitations and potentials of the child on a *symbolic level*. *Changes* become audible before becoming part of the consciousness and can be worked out verbally or by a new focus of improvisational theme (cf. Mahns 2002).

Three case studies

1. Ralph: Destruction and repairing

Ralph is seven. His father is in prison for attempted murder. Since then, Ralph is mainly preoccupied with death, ghosts, zombies and similar objects. He finds it very difficult to direct his feelings towards the outside. He might just trip somebody up when he feels like it, kick him or her in the stomach or strangle the person. I had ten individual sessions with him. In the beginning he was very much attracted by the interior space of the old untuned piano. It was a kind of fear/pleasure-mixture (*Angst-Lust*) which came out of the sounds he produced by plucking or beating the strings. In another session Ralph played the 'avenging angel' (*Racheengel*) and played with a wooden mallet on a small and fragile Indian drum. I had a strong feeling of pain, but let him go on. Finally Ralph reached what his subconsciousness wanted to repeat: destruction. The drum-skin broke. After one long minute of silence this experience gave us a chance to work upon feelings of vigour, hate and destructive impulses on the one hand, but also on shame and guilt on the other. In the next session we repaired the drum, which was a kind of integration on a concrete level. At the end of our sessions Ralph longed to invent melodies on the *glockenspiel*. One of those melodies became 'Ralph's song' which he proudly performed for his school class.

2. Zoran: Bringing the gold to the outside

Zoran is ten. His family came from Kosovo to Hamburg in Germany. In school Zoran does not talk to anybody. At home he is said to be alive, dominant over his four sisters, and sometimes aggressive. In school he does not communicate with anybody. His dark brown eyes are not able to hold eye-contact. Zoran had visited a special school for children with speech disabilities. This had to effect on his *elective mutism* (cf. Mahns 1999). When he first came to me, a special school for slow learners was in discussion, because nobody really knew his capabilities.

I had forty individual sessions of AMT with him. I added to the musical environment with paper and crayons for him to draw something, particularly after our musical improvisations. One picture from the very beginning showed a boy with a pickaxe in his hand, standing in the entrance of a tunnel. Then a big block of grey rocks. Behind this barrier

the inside of a mountain, grey with a few yellow pieces of gold. For me this was a rather *symbolic drawing*, showing Zoran's potentials – the gold inside himself – as well as the difficulties and the way lying before us. By improvising with him, listening to our taped music, and by using his strong potentials of drawing, we created a strong emotional basis. So I could risk using words more and more. Zoran did not talk for nearly one year in our sessions. The only word he used was a quick *Tschüß* ('Bye') when leaving the room at the end of a session. One of his conflicts was living in two different worlds and cultures, moreover the consciousness that his parents have the strong desire to go back to Kosovo, whereas he feels German and doesn't identify with his parents' roots. Another 'problem' was that everyone in the school had been very nice to him, reading his wishes from his lips. This made the development of autonomy rather difficult, and I had to work with the system (school class, teachers) as well. Working with this had a strong effect: Zoran began to take the initiative more and more in our activities, and in due course he used his voice, first by whispering words like 'Yes' or 'No', then other words like 'mole' (*Maulwurf*), which he selected out of other animal names we used for musical phantasy tours. Later on he began to use words also in the class. At the end, talking about music while listening to the tape became more and more natural. Meanwhile Zoran is still attending a normal public school. It became obvious that he is a boy of highly developed intelligence and sensitivity, a 'treasure of gold' which had been buried deep inside the mountain.

3. Nancy: Discovering the shadow

Nancy was a nine-year-old girl, well-adapted, a bit shy, and unpretentious. She was very afraid to go to school, especially before tests or other challenges, like leaving for an overnight excursion. Dramatic psychogenic symptoms, mainly a paralysis of her legs, have already been treated by medical doctors. She has had operations on the appendix and on the inguinal hernia, but without any alleviation of her suffering. Nancy was sent to the psychiatric department of the University Hospital of Hamburg, where the psychiatrist found out, by giving her placebo, that there was nothing physically wrong with Nancy. In cooperation with him I developed a music therapy program for Nancy, consisting of improvisation, relaxation techniques and percussion training at the drum

kit (including the bass drum), with the aim of reaching Nancy's emotionality and her body-awareness as well.

Within twenty individual sessions it became obvious that one feature of Nancy's life was her great *anxiety* not to make mistakes or stumble. This led to a kind of extreme cautiousness when moving her arms, in expressiveness, behaviour, and social interactions.

Nancy came into the first session suppored by two crutches. Her music was fragile, cautious, and also rather sad and *depressing*. I had the strong feeling to give her melodies a strong basis. As a kind of countertransference feeling I took the role of her crutches.

In one important episode Nancy was talking about her conflicts with Stefanie, a good-looking, athletic girl, dominant in the class, sometimes rather insolent to children and adults as well. Nancy's feelings concerning Stefanie were changing between jealousy and hate. We explored this ambivalence by the splitting technique, and Nancy discovered the 'Stefanie in herself', as a kind of 'shadow side'. This experience gave her a great deal of richness in expression and strength.

The next task was then to encourage Nancy to give up the view that she was interesting and important in her class because of her disease. Everybody had been very kind to her, whenever a staircase needed to be overcome, or whenever the class had to adapt to her tempo, namely on an excursion. The more Nancy opened up to her aggressive side, the more she became able to use her energy much more satisfactorily.

It was not surprising that she has now been elected as the speaker of her class. She is still quiet and sensitive, but now shows more of her strength and a good understanding of the conflicts in the class, particularly between the different factions within the girls' group that are fighting against each other, mainly between the anxious on the one hand and the wild and limitless ones on the other.

The function of music

One important question concerning AMT is: What benefit can children get out of improvising? Langer says that *music* can be seen as a *symbolic* and *logical expression* of human feelings and interaction. This means that music has many functions. In general terms, music can express an interactional disease *and* music is a way of dealing with interactional disease (Langer 1951). More specifically, I am working with a model of four *psychodynamic functions* which has been

developed for the hermeneutical understanding of compositions by Trapp (1975). I am using it for the understanding of the meaning of improvisations in therapy (Mahns 1984):

- function of Covering;
- function of Doubling the Self;
- function of Contact;
- function of Exploration.

Music – used in the way of *covering* – is a chance to contact the Self with the aim of security. An example is the baby's babbling monologue. He or she is covering her- or himself with sound. Another example is the adolescent walking along the road, covered by the sound of her or his personal stereo.

Zoran got an emotional ground by our improvisations. Music had been a 'fertile soil' whilst on this level of interactions I could show him my presence as a partner in sound. Nancy, at the beginning, enjoyed it when I covered her with music. Sometimes I tried to give a bit of a rhythm, I took over her cautious sound and mood or I answered to her melodical motifs. This reached her in the part of her life where she got help, sympathy and understanding. Ralph arrived at another object of exploration at the end of our sessions. This symbolizes increased desire of happiness and security. In some aspects he is covering himself with a sound which had seldom been an aspect of his life before.

Music – used in the way of *doubling the Self* – is the discovery of being together with one instrument or the own voice producing sound as if there were one Self and another Self at the same time. Whistling or singing in the dark can have this function, i.e. with the effect of reducing anxieties.

Ralph could strongly identify with the strings of the old untuned piano. He was able to face sounds of horror and dark shadows and could talk about the terrifying events he had experienced in reality. This kind of mirroring had a strong effect on him, because this showed him that he is not alone with his destructive impulses. Such sounds are part of the world. And – as emotions and phantasies – they are allowed. When Nancy worked out her relationship to Stefanie, she was shocked about the fact that there are aspects of Stefanie in her. The experience of 'this is also me' was a necessary step for an inner change. It was the other Self, the shadow side of her which Nancy was facing in our musical activities.

Music – used in the way of *contact* – is a strong way of touching somebody on a symbolic level, sometimes with the same effects as physical touching. This leads back to the earliest dialogues of the child.

This had been very important in the therapy with Zoran. A kind of pre-dialogue and contact came up when I suggested a way to play: we played a question–answer improvisation without eye-contact. I put a big cupboard between us. Here Zoran got his first confidence in symbolic touching. Those kinds of examples are showing a specific kind of developmental stage within the symbolic interaction. You can speak about pre-dialogue or dialogue, which is based upon the 'fertile soil' of resonance in musical relationship.

Music – used in the way of *exploration* – might contain experiment, practising or inventing. Within the exploration of instruments as part of the material from the nature outside, human beings can experience their own potentials, their own limitations. An example is the playing of children, when they try to make as much noise as they can – on a drum, with rattles or vocally. Ralph explored the resistance of a drum-skin and went over a border. We know the drum can symbolize strength, power, steady rhythm, and so on, and this shows what he is fighting against and/or longing for. Zoran sometimes used the instruments like toys, i.e. we developed the idea of playing ice-hockey with two drum-sticks and one head of a xylophone-mallet.

Final thoughts

My way of proceeding is possibly both prophylactic and psychotherapeutic work as far as the time of the intervention is concerned. The main principle of the *integration model* is: no child should be sent to a special school for slow learners, emotionally disturbed or speech handicapped children (cf. Mahns 1996a). Because of this special quality of being prophylactical there is a good chance to reach the child before things go completely wrong.

You might call the work with Ralph a kind of crisis intervention. A dramatic conflict from outside which he could hardly stand without expressing his destructive impulses against other children had been the cause of the therapy. Zoran's method of dealing with two different cultures had been, on the contrary, more a kind of an 'implosion' which made it necessary to bring something of the *inside* to the *outside*. Nancy had developed severely psychosomatic symptoms to avoid the dangers of life, which would have meant: acceptance of risks, mistakes, aggressions and change.

In all of the three cases *musical improvisatons* developed a strong *symbolic meaning* in the sense of meeting the child (covering), strengthening autonomy (doubling the Self), creating a dialogue (contact), and making development in expressiveness and change possible (exploration). When we look upon the 'integrative task' mentioned above, to understand at a very early stage even slight obstructions in character and to prevent these becoming ingrained with the help of careful interventions, so that these slight obstructions do not become manifest, it seems evident that the method of analytical and improvisatory music therapy is aiming directly at the *re-integration* of a child in school. For this process it seems to be effective to explore the psychodynamic meaning of the improvised music by the help of the described levels and to use those particular ways for therapeutic reflections.

For successful learning processes the following presuppositions are necessary and can be reached by music therapy improvisations:

- ability of *dialogue*;
- ability of developing *curiosity*;
- ability of being open for *new experiences*;
- ability *of cooperating* with others (starting within the *dyad*)

This has to be followed by another statement: in order to increase individuality *and* difference, it is necessary to apply flexible offers or settings to the individual child and to link them together. This can also serve to humanize schools as a whole. And, not to forget, it is not only more human than segregation, but it makes learning processes more satisfying and effective as well.

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CHAPTER 8

The Role of Music in Analytical Music Therapy – Music as a Carrier of Stories

Colleen Purdon

Introduction

This chapter is a brief reflection on the role of music in Analytical Music Therapy, from my personal reflections on this theme, that were prompted by an invitation to present at the Ninth World Congress of Music Therapy in Washington DC in 1999. Over the course of many years, and varied centres of clinical practice, there appear to be elements from the Analytical Music Therapy training and theory that have remained constant for my work, and others which, for various reasons, are no longer relevant or helpful. A central concept that has emerged in my work is the importance of stories for clients, and for me as a music therapist. For this reason, this chapter begins with two stories from my early days in the field of music therapy, and the early days of the development of Analytical Music Therapy.

> In 1975 I travelled to London to study music therapy at the Guildhall School of Music and Drama with Juliette Alvin, because there were no such programmes in Canada. It was a curious voyage, this study of music therapy; a voyage to a new city, far from my village roots in Canada, and a musical voyage into the strange land of free improvisation. My rather conventional Honours Music degree did not prepare me for the atonal musical exploration that I was forced to take part in with Alfred Nieman. Each week I faced a new and more challenging atonal and improvised inner landscape, beginning with my first trip to the grand piano to improvise a piece called 'A Duck Flying Over Norway' for my equally bewildered classmates. Alfred took away all of my comfortable habits at the keyboard – no major thirds, perfect fourths or fifths, octaves, major or minor chords were allowed, and he pushed, pulled, humoured and cajoled me into a

methodical musical exploration of myself. We all witnessed each other's journeys – we listened with respect, encouraged and critiqued, while we found our way through this new musical landscape, and in the process, found out a great deal about ourselves and each another. And Alfred, he laughed with glee at our successes, clapped his hands in wonder at our accomplishments, and never spared us in his thoughtful comments.

One day, a fellow student, Ole Teichman Mackenroth, asked me if I would be interested in doing Intertherapy training in Analytical Music Therapy with Mary Priestley. I had enjoyed Mary's presentations at the Guildhall, and was beginning my practicum with her at St Bernard's Psychiatric Hospital, so I agreed, even though I wasn't sure where to find the money. Ole and I began working with Mary at her London studio. Every week we explored techniques of Analytical Music Therapy, using free improvisation and verbal processing of our experiences. Mary was a guide and teacher in this work, taking us step by step through the experiences of 'holding', 'containing', 'splitting', 'guided imagery and music', 'reality rehearsals', and working with dreams, drawing and sea shells. Ole and I took turns being the 'patient' and the 'therapist', with Mary providing us both with a theoretical framework and insightful feedback about transference and countertransference phenomena. But more important than the techniques and theory was the experience of being a 'patient' for the first time. Taking a step into myself, and sharing myself in a profound and new way with another human being was a nerve-racking process. This learning to trust someone with my shortcomings and vulnerabilities was much harder than learning to be the therapist. The challenge of making sense of my music and half-formed thoughts was much more difficult than containing or supporting another person in their journey.

These two stories are as relevant today as they were 25 years ago. The day-to-day work in music therapy involves us in a detailed exploration of sounds and silences with people who are vulnerable and often in great pain. It confronts the music therapist and the client with personal limits, vulnerabilities, beliefs and attitudes, while revealing opportunities for growth and development manifested in both the music and the words, and through a unique therapeutic relationship.

Reflection on the role of music

There may be some value in reflecting more closely on the role of music in Analytical Music Therapy, from the perspective of a clinician who has worked in

many clinical settings and with many different clinical issues. The following points are the result of a 'reflection and distillation' exercise I conducted with myself, focusing on two central questions, and illustrated by brief examples from the clinical work.

1. What constants have there been in the role of music in my work with diverse clinical situations, with widely differing client needs, and over a time period of 25 years?
2. What has changed in my understanding of the role of music over the past 25 years of music therapy practice?

This reflection and distillation exercise was bit like flying high over 25 years of clinical work, looking down into music rooms in Canada and Germany – listening with my mind's 'ear' to the thousands of improvisations that I have been part of. I started in a bright sunroom, at the end of an appalling ward, in an institution for developmentally delayed adults, where I decided to use free improvisation and Analytical Music Therapy techniques with dual diagnosis clients. Then on to Herdecke in the Ruhr, Germany, to a high-rise room where I was privileged to work with German students of music therapy while they explored themselves and the method as part of their music therapy training, as well as down on the first floor where I worked on the psychiatric unit, in a children's outpatient clinic, and with delinquent adolescents. On to a large, comfortable music room at the Klinik im Warndwald, where I introduced analytic group and individual music therapy to alcohol and drug dependent individuals as part of their five-month residential treatment programme, and finally back to Canada to the private music therapy practice I share with my partner Joachim Ostertag, in Owen Sound, where I work with abused children and adolescents.

What has remained constant in the role of music?

1. *Music as a Bridge*: Mary Priestley describes music as 'our bridge, the magical meeting place between two people' in her book *Music Therapy in Action*. Music acts as a bridge in many ways:
    - as a sound connection between two people, linking their experiences and stories in a concrete form that can be heard, described and explored. This sound bridge becomes an object itself, that can strengthen and add meaning to therapeutic relationship, and provide access to information and insight;

- as a connection between individual worlds of experience, that does not value one more than the other, or make judgement on either;
- as a link between ambivalent thoughts and feelings, setting contrasts in the room at the same time, and allowing both to coexist;
- as a primal connection offering opportunities for deep shared experience, deep levels of empathy, acceptance, and understanding;
- as a connection between the inner world of each person, and their everyday reality;
- as a connection between the world of speech and the world of feeling.

An articulate and intelligent man, with a serious addiction problem, struggled in the group music therapy sessions for many weeks. He took on the role of the group sceptic, often refusing to participate in improvisations, reacting to the music of the group with sarcasm and ridicule, and taking every opportunity to direct negative comments towards the therapist and the whole notion of music therapy. The group played a very beautiful, quiet improvisation about autumn. Following the improvisation, and listening to the tape, we went around the circle and group members talked about their experiences. When it came time for his comments, I fully expected his usual barrage. He began to speak about the forest we could see outside our window, and how the music was like the rain drops falling on the forest floor – the steady and delicate sounds brought him a great deal of peace. There was a very long silence in the group while we allowed his beautiful words and newly respectful response to sink in. The music had bridged his negativism and need for negative control in the group, and brought him to a new place.

2. *Music as a Safe Place*: The therapeutic setting must be a safe place for people to explore themselves and make change. Improvised and composed music offers many opportunities for people to find places of safety, and to create safe places, where they can do their work.
   - The musical themes and topics for improvisations in the sessions come directly from the client, and although the musical

expression can be challenging or painful, the client knows clearly that it has been her or his choice to go to this place in the music.

- The therapist uses techniques such as holding and containing to provide a musical context or framework in the improvisation that allows the client to explore and experience safely within.
- The therapist and client develop musical motifs over time that are used as signals to support connection and safety. A rhythmic pattern, melodic *leitmotif*, or tonal signal can be used to reassure the client of the presence of the therapist, to have a short 'breathing space' from intense emotions, or to signal the need to stop.
- The music itself can be a safe discharge of emotions or tensions for the client, especially to express anger, disappointment, grief, or an intense mixture of emotions. The music can be used to 'clear the air' safely, followed by a verbal, or musical exploration of the issues to gain insight.
- The improvisation can allow the client to go with someone to revisit traumatic incidents, or potentially overwhelming feelings, in a safe way. The music may provide comfort while the client talks or thinks about painful experiences, and improvised songs can allow the client to explore wishes, dreams, and painful experiences in a safe way.

A teen girl comes to music therapy because of physical, emotional and sexual abuse in her family. She is now living in permanent foster care, while her four siblings are scattered across two counties. She is extremely fearful and shy, and not convinced at all that she needs therapy. Her social worker feels that it is important for her to have therapy with a woman because she 'hates women'. She loves music though, and we carve out a comfortable place around our shared interest in instruments and improvisation. We have developed a safe way for her to start exploring the impact of the abuse on her life, and on her current relationships in her foster home. I sit at the piano and start to play anything at all, while she talks about her week, and plays on various instruments in the room. This wandering around, and establishing contact gradually evolves into an antiphonal song, that explores the issue of the day (What do mothers

want, what do mothers want?). We stop the music often to write down the song as it comes along, and often then tape the entire song in a 'finished format' – another safe way for her to look at herself and her needs.

3. *Music as a Carrier and Teller of the Client's Story*: As music therapists we 'listen for the words in the music and the music in the words', as Mary Priestley so aptly put it (Priestley 1975, p.250). Music captures the complexity and layers of our human stories in ways that words alone cannot:

   - music tells the story of the client in a different way, often expressing aspects of the story that cannot be expressed in words – the emotional content, and the relationship aspects;
   - music can lead the client and the therapist to stories from the present and past that the client could normally not share, because of verbal limitations, or fear;
   - music can give the client a sense of control over the telling of the story, and supports the client's unfolding story over time, and in a way that is safe;
   - music can help connect or reconnect the inner story of the client (the feelings, fantasies, fears, memories), with the story of events and experiences in the outer world. This is especially important with clients who have suffered a disruption or break between their inner and outer experiences, or who have had real experiences of trauma neglected or disbelieved.

   A developmentally delayed man is referred to music therapy because of acting-out behaviours (urinating on furniture, aggressiveness, anxiety), and because previous music therapy had been helpful for him. After several sessions, in the course of the music making, the client disclosed sexual abuse by a community volunteer. The tape of the disclosure was provided to police as evidence, and the referring agency was able to take immediate action to protect him from further harm. The protective actions of the agency, and supportive role of the therapist, and ongoing music therapy resulted in him ceasing his acting-out behaviours. There were no charges laid in the case, as the victim was not considered a credible witness because of his developmental delay, and speech difficulties.

A four-year-old girl was referred to music therapy because of head trauma as a result of a car accident that resulted in a long hospital stay and separation from her family. She developed a routine in music therapy where after greetings and some initial musical explorations, she took a doll and began a musical story with songs, instruments, props, and drama. Each week she added to the musical drama: the baby was hit on the head violently, was taken to the hospital, the doctor put on a bandage, the mother and father came to visit, the sister stayed at home, and, finally, the baby went home in the car. The musical drama was repeated, varied, and reworked many times, over several months. In the final session she put the baby (now without the bandage) under the piano bench, and said she was fine, because the music had made her better.

4. *Music meets Human Needs*: Music can be a powerful and safe way to meet basic human needs expressed in the therapeutic setting:
    - music can provide concrete comfort, nurturing, and soothing for clients who need a tangible and immediate response from another person;
    - music can provide a cathartic experience or release;
    - music can provide a way of avoiding, or a creative way of dissociating, when a person is feeling overwhelmed by intense feelings or memories;
    - music expresses what a person cannot say, but is impossible to keep quiet;
    - music can symbolically fulfil needs for acceptance, caring, and help;
    - music allows for the effective expression and sharing of a vast array of emotions, in their wholeness and complexity.

A six-year-old girl was referred to music therapy because of problems in school with her attention, and to help her deal with the death of her grandmother. She was in permanent foster care, with her older sister, because her mother was unable to protect her children from several physically and sexually abusive partners. She loved music and play, and early in the therapy found a hymn book in the piano bench. We sat at the piano, and she picked out hymns that I didn't recognize, and neither did she. She announced that she would like to sing a hymn for her grandmother up in

heaven. We picked a song from the book, and she played along with me, and she sang to her grandmother – making up the words – all about missing her so much, and wanting to see her, and knowing she was in heaven. She cried a little as she sang, then ended the song, and closed the book. We talked a little about her song and missing her grandmother, then she closed the piano. After that session, she was very careful not to let me play the piano, often coming and closing up the keyboard when I started to play, even as her play and music in other areas unfolded with great emotional intensity.

5. *Music supports the Development of Identity*: Improvised music can foster the development of a person's sense of self, and the demarcations between self and other:

    - songs, musical stories, and musical play can focus attention on the uniqueness and differences of each person, that the client can hear and experience;
    - musical signposts in the overall process of the therapy mark specific developmental stages in the therapy, and also in the healing process for clients;
    - music can celebrate achievements in therapy, and in the 'outside world' for the individual;
    - the experience of group members hearing the uniqueness of their group, and of each individual person in the group is a powerful learning experience;
    - music and musical forms introduce concepts of boundaries and separateness between you and me, that can be explored, and played within the therapy;
    - music can stimulate the recovery of forgotten memories and images that can help a client feel that there are not parts of her or himself that are lost to her- or himself;
    - music loosens up rigid or static attitudes and feelings, and promotes dynamic changes in the individual.

    A young man was working in his therapy on the recovery of memories from his childhood. He played a long improvisation with the therapist that was empty of feelings and disconnected. There was a flatness in the music, and a strong sense of loneliness. After the improvisation the young

man was deeply moved. He spoke of an image he had while he was playing of himself as a small child, alone in his room for hours on end, and tied up so he couldn't get out of his bed. It was an important point in his work, and in understanding his present relationship with his parents.

What has changed in my understanding of the role of music in Analytical Music Therapy?

1. I have largely abandoned any attempts at psychoanalytical interpretations of music, or understanding the musical expressions in these terms. At this time I work with physically and sexually abused children and adolescents, who struggle not only with the impact of the trauma from past abuse, but also face dislocation from their family, friends, and supports, and often the risk of future abuse. The work is practical, and focused on establishing safety and dealing concretely with the very real threats that these children have to their physical and emotional safety. It is critical for the music therapist to address the abuse and trauma in a way that places the responsibility for it clearly with the perpetrator, and not to infer that the victim of the abuse is in any way responsible for the abuse he or she has suffered. Some aspects of psychoanalytic theory have been unhelpful, or have re-victimized clients who have been abused, by placing responsibility for the abuse on the victim while ignoring their safety needs.
2. I have expanded my sense of what is 'music' to include a very broad scope including: elements of music, musical play, spoken words, drama, movement, play and art. In any session, the actual music-making is part of a much larger musical context that may include many modalities. Understanding comes from the whole of the play, not by isolating the strictly musical portions in the session.
3. I believe that there is an exciting piece of work to be done in the area of music as the carrier of children's stories. There is the potential to use this concept, which spontaneously occurs in my work, in a more rigorous way. When I am working with a child in the creation of the 'opera of their life', playing the roles and music assigned to me, and working week after week on the themes of their lives, I believe that we cannot isolate music from the concept of story. The children express such an intense need for their musical

stories, an absolute concentration in the work, and an amazing ability to remember the story lines and themes over weeks. These factors point to the need for music therapists to do more exploration in a multidimensional approach in their work with children.

4. My focus is no longer strictly on the examination of the music and the analysis of what happens in the music in the session. There is a danger in focusing too intently on the inner world of the client, or the small world of the music therapy room. The information and expressions that clients share with us will only lead to healing for them when we as therapists are connected to their 'outside' reality as well. Specifically this means that all the therapy in the world will not help an adult or child who is living in an abusive or dangerous situation, and no steps have been taken to address their safety. I spend much more time screening for abuse, attending to practical safety issues, and staying well linked with community supports and agencies that can support vulnerable clients.

Conclusion

Music is a powerful medium that can carry the stories of clients in many ways:

- musical motifs and structures can evolve from week to week in the music therapy setting, as the client gradually unfolds the stories that detail their inner world, and the concrete situations and dilemmas they are confronted with in their day-to-day life;
- music carries the story from the client to the music therapist as part of the therapeutic relationship, and in a form that offers the potential for deep understanding and sharing;
- musical play allows the client to revisit, change, and re-invent their stories in ways that can foster the development of insight, confidence, or an increased capacity for risk taking;
- the music, and the story within the musical expression, can be taped, or transcribed, and allow clients to take their story out of the therapy session to share with their larger circle, or as a record of their work in the therapy session.

Regardless of the function of the music, or the way in which the client's story is expressed in music, words, play, or on paper or a tape, it is the role of the therapist to honour and respect these stories, in the way they are presented, and to ensure that every client's need for safety within the music therapy setting and outside the session is clearly attended to throughout the therapeutic process.

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CHAPTER 9

Improvisation as a Musical Healing Tool and Life Approach

Theoretical and Clinical Applications of Analytical Music Therapy (AMT) Improvisation in a Short- and Long-term Rehabilitation Facility

Benedikte B. Scheiby

In this chapter I would like to convey how AMT can be applied in a medical setting and discuss important aspects of the reality of the music therapist working as an AMT music therapist in this type of setting.

The first thing one feels upon entering a rehabilitation facility is to be very grateful for every day that one is in possession of an intact body. You see young and old people sitting up or reclined in wheelchairs, some without legs or arms, and some paralyzed in various parts of their body. Some individuals' bodies are shaking constantly, some are blind, some possess only one eye, some exhibit large scars on different parts of their bodies, some are attached to machinery – such as feeding tubes or oxygen tanks – which they are dependent upon for survival, and some with light beam equipment and computerized spelling boards which they are dependent upon for communication. When I first looked into the eyes of these people I saw pain, sadness, despair, frustration, anger, helplessness, longing, questions, resignation, neediness, loneliness, and intensity.

After taking a deep breath and overcoming my initial shock (after all, it could have been me!) I said hello to some of the patients as I passed by. Some were trying to say hello and communicate something to me, but it was hard to decipher what it was. Others were vocalizing sounds or saying something that resembled words. And some were greeting me with a big smile and welcoming words.

I thought to myself that for these clients, AMT must really make sense, as they had to deal with such fundamental bodily and psychological existential issues every day. I wondered why I had not met AMT music therapists working with this population or read articles about AMT in a medical context. The answers would come later.

My existential issues stimulated by being a full-time music therapist in a foreign culture, speaking a foreign language, teaching, writing articles, doing research, presenting my work at professional conferences – all while being a mother of young children – suddenly, in a single drum beat, became minimized. Here are young people bound to a wheelchair, some of which may eventually recover, but most will be sitting in a wheelchair for the rest of their lives, while being dependent upon other people and with very little control over any aspect of their daily life or future.

My philosophy is that there always is a deeper meaning with things that happen to you or things you do in life, even though it seems not to make sense in the moment. Now I realized what the deeper meaning was of spending my time, energy, and money on studying and working in three different environments, which may have seemed completely unrelated to any music therapy reality.

Prior to my decision to become a music therapist I was studying medicine for three years and working at a variety of medical settings as a medical assistant in Denmark. I never finished the education, even though I was highly motivated. I wanted to become a psychiatrist using active and receptive music as a part of the treatment, but what made me discontinue my studies was how the patients were treated. My impression was that only the medical issues were addressed and the patients were treated like objects, not as human beings. Psychiatric patients were primarily treated with medication, as no other modalities were available. The working conditions of the physicians left much to be desired, consisting of long hours with little time available for patient contact.

Second, while I was studying for my Master's degree in Music Education at the Institute of Music at the University of Copenhagen, I had to support myself financially for seven years, and I worked as a part time nurse's aide at a small nursing home. This job helped me to understand the needs of the long-term clients who wind up having the treatment facility as their permanent home.

Last, my training as a bioenergetic psychotherapist (a three-year postgraduate clinical and theoretical training led by Olav Storm Jensen in Copenhagen) was going to serve me particularly well with so many clients having bodily traumas, verbal communication problems, emotional and cognitive problems.

The experiences mentioned at the beginning of this article also caused me to reflect on my training with Mary Priestley (1978–80), particularly the emphasis placed on including bodily work as an integral part of the music therapist's job. As part of her music therapy work at St Bernhard's Psychiatric Hospital in London she developed a body psychotherapeutic training discipline called Psychodynamic Movement, which consisted of authentic movement accompanied by improvised and composed music and a variety of relaxation techniques accompanied by improvised music (see also Chapter 12).[1]

What I did not know the first day I entered the hospital was that I would be taught a life lesson and skill. This was the ability to improvise, not only musically, but in all aspects of the job as a music therapist in order to make it possible for AMT to be implemented in the context of a large medical institution. I needed to become familiar with the different symbolic rhythms of the institutional life, the individual rhythm at a particular floor, the rhythms of the different staff members and members of the treatment team, and, last but not least, I had to establish the unique rhythms of the relationships with the clients. For me, having been trained and working as a rather 'sticking to the rule' analytical music therapist and trainer for 16 years, it was a challenge to become that flexible. It was essential to be able to help the patients to improvise in a broader sense than just in the music. This was a very important coping mechanism for the patients to acquire because their lives had changed from being able-bodied and in control of their lives one day, to losing control and being dependent on others the next day. And for that purpose improvised music used with a variety of parameters representing structure seemed to be a perfect channel and tool.

Treatment context

I am presently working four days a week at a short- and long-term rehabilitation facility for adults ranging in age from 18 to 100 years old. As an Assistant Director of the music therapy programme I have several functions: supervisor, clinician, student supervisor, and researcher at this 590-bed facility. The

1 Basic elements from this approach were further developed into a complementary teaching discipline by me and my colleague Inge N. Pedersen, (assistant professor in music therapy at Aalborg University and also trained by Mary Priestley) and taught to music therapy students in Denmark, Germany and United States. A description of this approach can be found in Scheiby and Pedersen 1989.

illnesses and conditions of the clients include stroke, cerebral vascular accident (CVA), traumatic brain injury (TBI), multiple sclerosis, Lyme's Disease, cancer, amputations, coma, heart condition, diabetes, cerebral palsy, Parkinson's Disease, Alzheimer's Disease and a variety of non-specific neurological trauma.

There is a 20-year tradition of using music therapy as a clinical treatment at this facility, and there is a tradition of doing research in music and neurological functioning, so an understanding of the basics of the discipline has been established. The music therapist Dr Connie Tomaino started up the current programme, which is unique in its model of integration between clinical work, research and student training. A national and international music therapy student training programme has been in place for several years.

Clients are offered individual and group music therapy sessions once or twice weekly. The music therapy is performed in a studio, at the bedside, or in the dining room area. The goals of the treatment are determined based upon the medical and psychological needs of the patients, who typically are referred to music therapy by physicians, psychiatrists, psychologists and social workers. Not all the patients who are referred are necessarily interested in playing music or in using music as a therapeutic tool. This can sometimes be the cause of an initial resistance. With the permission of the clients, the sessions are audiotaped or occasionally videotaped and documented in written form. The assessments are placed in the medical charts on the units.

In the music therapy department there are three full-time music therapists and two part-time music therapists, who have specialized in a variety of different areas:

- music psychotherapy, on the supportive level as well as insight-oriented;
- recovering short- and long-term memory;
- auditory cueing for gait training;
- music-assisted movement;
- auditory cueing for speech;
- electronic MIDI music therapy;
- spirituality;
- community building;
- quality of life enhancement.

- palliative care
- pain management

All the music therapists work in a holistic framework and can work in all the above areas.

Definition of AMT

In her 1994 book, *Essays on Analytical Music Therapy*, Mary Priestley defined AMT as follows:

> So Analytical Music Therapy is the name that has prevailed for the analytically-informed symbolic use of improvised music by the music therapist and client. It is used as a creative tool with which to explore the client's inner life so as to provide the way forward for growth and greater self-knowledge. (Priestley 1994, p.3)

I would like to introduce a slightly expanded version of Mary Priestley's definition. Analytical Music Therapy is the analytically-informed symbolic use of improvised or composed music as intervention in order to effect therapeutic change. Musical experiences and the musical relationship between client and music therapist are the main dynamic factors in the therapeutic process.

Mary Priestley writes primarily about the use of improvisation in her case studies, but in her video *Music and the Shadow* she presents a case with the use of composed music as a therapeutic intervention, indicating that she uses composition in certain cases. So my addition of *composed* music is valid in terms of following the origins of the approach.

The reason for adding *composed* music is that working with a population with neurological trauma means that one is working with client whose sense of inner and outer structure is damaged. To be exposed to free improvisation at the wrong time of treatment can cause anxiety, regression, resistance and reinforce a sense of inner chaos. The physical neurological structure of the clients is damaged and as a consequence their ego structure, memory and cognition may be impaired as well. To listen to composed music with a clear rhythmical, melodic and harmonic structure often creates a safe structure as a basis for developing interest in improvising musically. In the procedure that I have developed in applying AMT in this setting I make use of both composed music and improvised music in assessment and ongoing treatment according to what is clinically indicated in the moment. If composed music is indicated, I either

play or sing it myself to the client, or I use recorded music, if orchestral music is needed.

Psychosocial and physical needs of this population

I have identified these general areas of possible needs based upon descriptions of the needs of the client on the referral notes:

Psychosocial needs

- depression/anger/anxiety/agitation management;
- stress management;
- elevation of mood;
- improvement of coping skills;
- refocusing of the mind;
- improvement of self-confidence and self-esteem;
- improvement in patience;
- improvement of independence;
- improvement of intrapersonal and interpersonal communication skills;
- improvement of expressivity;
- improvement of motivation to participate in treatment;
- improvement of impulse control;
- improvement of socialization skills;
- marshalling of spirituality;
- mobilization of energy;
- release of energy;
- promotion of hope;
- promotion of comfort;
- improvement of life quality;
- improvement of reality orientation;
- emotional support.

Besides the needs that are based upon the assessment of the team members the client may, in the assessment session, come up with additional specific needs, or the music therapist may identify undiscovered significant areas of focus based upon the initial musical and possible verbal contact.

Physical needs

- pain and cramping reduction;
- pain tolerance;
- relief of insomnia;
- improvement of speech;
- improvement of gait;
- improvement of short- and long-term memory;
- improvement of mobility;
- improvement of cognitive skills;
- improvement of attention span;
- improvement of capacity to breathe;
- improvement of motivation to eat;
- improvement of endurance;
- improvement of ability to relax;
- reduction of fatigue;
- improvement of balance;
- improvement of range of motion;
- lowering of blood pressure;
- decrease of muscle tension;
- increase of blood circulation.

In reality, the music therapist is working simultaneously with psychosocial and physical needs, as body, mind and spirit are all interconnected. But there usually is a primary focus of intervention at any given time, although this can change.

Free improvisation as a tool for clients with neurological trauma

If one looks at the above list of psychological and physical needs, it makes perfect sense to use structured and less structured improvisation with this population. Because the AMT trained therapist has experienced AMT as a client, you have been indirectly taught certain general life skills through the improvisation practice. Moreover your identity has been challenged and you have been motivated to personal growth. You have had a place to express and identify emotions and to feel emotionally contained and nurtured. These musical experiences are directly translatable to many life situations, including those encountered by these clients.

The following areas of clinical concern often come to the surface and are addressed by the clients or me during the musical improvisational practice.

Trusting that I am good enough as I am even though I am missing certain body parts

Through learning to trust that the vocal and instrumental sounds that are made in free spontaneous improvisations are permissible, one can be led to important new insights. The sounds do not have to be perfect in any sense and are based on the principle of authenticity. Even though I am paralyzed in half of my body, and in that sense not perfect, I can trust that I am able to manage my life in the future, and I will make the best out of it as it is right now.

To take initiative and take charge

In the improvisations the music therapist will let the clients take the initiative to play or sing and support them in this. Sometimes, before the clients initiate the music, there will be a long pause or period of silence. In this pause, the clients are often confronted with fear and anxiety. When they learn to give themselves permission to sit with, express and overcome these fears musically, they become able to:

- take the initiative and make sounds, verbalize thoughts and feelings that formerly were withheld;
- take steps towards starting to initiate body movements that seem odd, because the body is functioning differently now from before;
- take the initiative to make plans for the future;
- take the initiative to step out of isolation, and make new friends;

- take the initiative to be actively involved in their personal treatment planning;
- take the initiative to try out new things that they have not tried before;
- take the initiative to get out of bed and go out and around instead of being isolated in the room.

In a treatment facility setting, clients are often accustomed to being taken care of and having everything done for them or to them. Tasks that one was formerly able to do are now done by others. That can cause a pacified state of mind where clients forget that they can still take responsibility for some things in their own lives.

Finding meaning in something that seems meaningless

Frequently, improvisations begin spontaneously with a client playing a rhythmic pattern or a client humming a tune, which starts the music. This is supported by the music therapist and the client goes where he or she needs to go. It may not have a specific meaning for the client in the moment, but when the improvisation is finished the client will verbalize about the music and ascribe whatever symbolic or actual meaning it had for her or him. A client may say a word or a sentence, or mention an issue from where the music can take off and get its own life. It may seem meaningless in the present moment, but in the end something significant is usually retrieved from the musical process and product. Often, the improvised music creates a bridge to the unconscious or to repressed emotions and thoughts. This bridge facilitates verbal processing of the meaning that the client assigns to the music. When a person experiences a physical trauma he or she typically struggles with the meaning of life now that he or she cannot do what they used to do, when one cannot be what one used to be.

Dealing with issues of being out of control and being in control

Because the clients have parts of their bodies which are not functioning or simply are not present (missing limbs), they often feel that they are also emotionally out of control. This issue is also triggered by the fact that they are living in an institution where so many of their daily needs are controlled by others, including when they can get in and out of bed, when to eat, what kind of food is served, when medication is given, when medical appointments are scheduled, and how their finances are monitored. The issue is also brought up by the fact

that the clients are in wheelchairs and some cannot self-ambulate but must instead wait for others to move them.

In free improvisation, where everybody has an opportunity to be the leader and the follower, this issue is dealt with constantly. A group member may start out a rhythm, a melody, or a tune, and everybody will follow this group member. If a person has difficulties doing this it will be processed verbally, and insight around the importance of being able to oscillate between the positions of being controlled and being in control will be released through practice and discussion.

Emotional expression, release, identification, integration and sharing

Certain physical trauma can cause a variety of psychological states of mind such as depression, anxiety, loss of emotional control, confusion, extreme anger and frustration, isolation, grief, denial, resignation, and stress. Free improvisation can offer the emotions a creative *gestalt* or form that can be identified and possibly verbally processed. Particularly for clients that have lost their ability to speak (stroke, multiple sclerosis), the free improvisation offers an opportunity to express feelings they are imbued with, to share them with other clients, and feel supported.

Often the emotions of the clients are expressed in the improvisations, but they are not being spontaneously verbally processed afterwards in relation to the music. The reason for this is that underlying issues that are somehow connected to the emotions that the clients are experiencing are coming up to the surface during the improvisations. These issues are verbalized spontaneously and processed by the clients and the music therapist in conjunction. As an example, a client in a short-term rehabilitation group was complaining that he was just hanging around and wasting time. Other clients joined in with the same issue. I asked if he could suggest a title of an improvisation. He chose the title 'I am bored to death'. I suggested that we all joined him in the music which was performed on percussion instruments, mainly drums and vocally. Frustration, anxiety and loneliness were reflected in the music as the most dominating qualities. In the verbalization afterwards he immediately started talking about his fears of 'ending up at a nursing home'. His lawyer and his social worker had told him that that might happen. He felt that he was not included in the decision process about the future. He did not have any family to help him out, so he had to depend on the lawyer and the social worker. To me he seemed stable and independent enough to be living in a place with supervision. I

promised him to look into the case, and after a re-evaluation by the social worker, he was put on a list for an assisted living apartment.

Clients with high blood pressure are able to monitor their blood pressure if they are able to relax and let go of tension. Emotional release through drumming and vocalization has been documented as being helpful in the process of learning to let go and relax. Therefore the spontaneous release of emotions that often happens during free improvisations can be facilitating for the purpose of controlling blood pressure and for the ability to relax and just go with the flow. Tension that causes sleeping problems can also be monitored through focal improvisation models that are designed to slow down tempo, dynamics and breathing.

Creation of transitional space for experiencing the living modes of being and doing

In free improvisation we oscillate between the modes of being and doing through moving between listening and playing. Clients that are forced to be sitting in a wheelchair because of a physical handicap are often forced to be more in a state of being, because they cannot act with their bodies as much as they could before. That can be hard for the clients to accept. In improvisation we learn to appreciate the being mode in the sense that one does not have to produce sounds in order to participate. You can be an active listener and still work, so to speak. You do not have to play an instrument. You can still take in and assimilate experiences. This state of being can be compared with the state of being that one experiences in an early mother–child relationship. It is a nonverbal relatedness, which can be very healing because it reminds us of when we were held and contained as a baby.

Dealing with issues of oneness and separateness – dependence and independence

Many physically traumatized clients have dependence issues. Initially, clients are highly dependent upon others and may get used to being helped so much that they become afraid of making decisions on their own and taking initiative. This can become a fear of leaving the institution and returning to one's home. Other clients may become very frustrated and angry because they are so dependent upon others. In musical improvisation, these issues come up very often and can be dealt with symbolically and/or concretely. Perhaps a client in the beginning of a treatment is afraid of playing or singing alone. The music therapist offers company in the music at the beginning of the sessions and gradually, when clients are ready, lets them play or sing alone, when they feel

strong enough to stand on their own. Dependency issues often emerge for clients who, before they became ill, already had problems with being dependent or independent. The musical improvisational space can offer a place where

> …two minds meet in a shared reality, but it is more than a cognitive resonance, for it is kinaesthetic in character, highly fluid in motion, and charged with a variety of affective states. Originating within this space, mother and child establish a bi-polar relationship of oneness and separateness, oscillating back and forth, feeling and being in a state of formlessness and union and then emerging into form and differentiation. (Robbins 1994, p.48)

The music therapist and the client oscillate in the created music between these two ego-rhythms, and the client learns to be comfortable in the oneness and the separateness.

In terms of separateness it is often experienced in clients that have had physical traumas, that it is hard for them to set boundaries. The body has often undergone regression, and so has the mind. The client has a part of him or her that has regressed to a developmentally very young place, where a need for oneness and symbiosis is apparent. This may mainifest itself in the music in ways such as having difficulties ending improvisations, a need to be contained and held by the music therapist's music, a need to merge musically. It may manifest itself in the music being very intense and carrying an overwhelmingly strong emotional component, such as having an undercurrent of extreme sadness, extreme anger or extreme fragmentation. In particular in stroke victims one often gets the impression that the super ego has been somewhat cancelled, and the clients are struggling with the seemingly uncontrollable stream of emotions emerging. Therefore it is important in the music therapeutic assessment to listen for the presence of a variety of developmental levels in the music. These levels can be identified, lived through in music, and the client can be helped to reach her or his appropriate psychological developmental level at the same time as the physical rehabilitation taking place.

Experiences of being connected bodily, mentally and spiritually

Many clients are in the situation of only being able to move a foot, an arm, a nose, and are daily experiencing bodily loss and feeling disconnected as a human being. By applying MIDI-technology to the instruments it is possible for the clients to improvise and interact, connect and create a musical product

together with a group of people in the same situation. This helps the clients to feel self-esteem, a sense of empowerment and connection, and gives them an experience of being able to use a body that in other situations seems helpless. An instant connection between body, mind and spirit is created through control over bodily movements which are activated by focusing on activity while emotions are experienced and spiritual resources are activated. Recent neurobiological research has proved that working with emotions in an interactional way can affect and develop neural networks:

> The ability to participate in processes of play and affectional interaction may be a key determinant of both information flow and the brain arousal that help to shape developing neural networks. (Tucker 1992, p.80)

Facilitation of access to the unconscious thoughts and feelings through improvisational activity

Free improvisational activity – where no prior structure is given and where the musician has an open mind to what may happen – can allow a person to move behind the defences and get access to unconscious resources and 'messages', similar to the way in which dreams provide important information about our life. The music can function as a bridge between the conscious and the unconscious. Frequently, in the verbal processing of improvisations clients report that they saw certain images, felt certain unknown emotions, or got in touch with childhood memories. Recent neurobiological research indicates that there is a close connection between the right brain and unconscious thoughts and feelings. This may mean that clients who have suffered brain damage have the potential of making a re-connection with parts of the brain that have been damaged through working with the unconscious.

> I have argued that the emergence of unconscious thought and affect reflects the maturation of the right brain, the hemisphere that is responsible for the manifestations of unconscious processes. (Schore 1994, p.538)

It is common knowledge in psychoanalysis that the unexplored unconscious processes constitute the obstacles to free flowing energy, so here is one more statement that indicates the importance of gaining access to the unconscious. Often clients with physical traumas complain about being physically and mentally stuck (sitting in a wheelchair the whole day contributes to this feeling), and the act of spontaneous playing on instruments and spontaneous vocalization can free up the 'stuck' energy.

Necessary preparations for music therapy sessions

In a treatment facility setting a large amount of work has to be invested in preparation for the music therapy session. Setting up an appointment time that is convenient for the client among all the other medical appointments and rehabilitation therapies is often a big puzzle.

One has to establish good communication with the staff at the unit where the client is located and inform them of the importance of supporting the client in coming to music therapy. I usually fill in a notification slip where the time and place of the music therapy session is written and give it to the client and staff members who take care of the client. Many clients have memory problems, so one cannot rely on the client remembering the scheduled time. Participating in the weekly care plan meetings for the clients is a great help in facilitating communication relating to the client.

The fact that the clients often have an irregular daily rhythm influences the regularity of the sessions. Even though it is ideal to have the same client at the same time at the same day of the week, it will not always be possible. Sometimes the client is at a medical appointment, in rehabilitation or in bed. The music therapist has to be able to improvise around the schedule of the client that is often interrupted. Clients who are wheelchairbound often have to be brought to and from the session room. They depend on other people to help them with the transportation – sometimes there might not be anybody available to help them at exactly that moment when they need to be transported to the music therapy session, or maybe the lifts are occupied.

When I realize that a client is not on time for my session I often talk with the lift operator to determine whether he or she has seen my client somewhere. Often the lift operator is the right person to ask because he or she is familiar with the clients and their routine.

In order to prevent interruptions during sessions, one can post a sign on the door that indicates 'a session is in progress – please do not disturb'. The fact that interruptions often do happen might prevent the client from being able to go in depth with the work. Providing as much information as possible to primary caretakers and roommates about the time and place of the music therapy session is helpful.

Assessment

In this chapter I will focus especially on a developed AMT assessment model designed for this population, as a detailed and correct assessment can be crucial for the treatment process and the outcome of the treatment. The researcher and clinician Dr Joanne Loewy, in her article on music psychotherapy assessment, supports this with many examples from work in a medical setting:

> Pivotal to the formulation of a treatment plan is an assessment protocol, which provides a format for introductory themes (or issues) that may serve as a baseline for the future course of therapy. (Loewy 2000, p.49)

In the first session I make an assessment of the client on the basis of the session's musical and verbal content. If the client does not want to play or sing, I assess on the basis of the verbal content and wait with the musical assessment until that is possible. Assessment results, goals and objectives are documented and placed in the client's chart. Short-term clients are reassessed after one month and long-term clients are reassessed after three months. I perform ongoing assessments throughout the treatment process in order to monitor the client's progress.

I have developed an assessment model that has been helpful in my various applications of AMT. These are the areas of inquiry that I consider essential to derive clinical data from the structured and non-structured musical experiences that the client is involved in. In the first session clients are asked to play and sing together with me and are also asked to engage in independent musical work such as improvisation. If the clients are, for some reason, resistant to engagement in playing/singing/listening in the first session I do music-based assessment whenever the client has overcome the resistance.

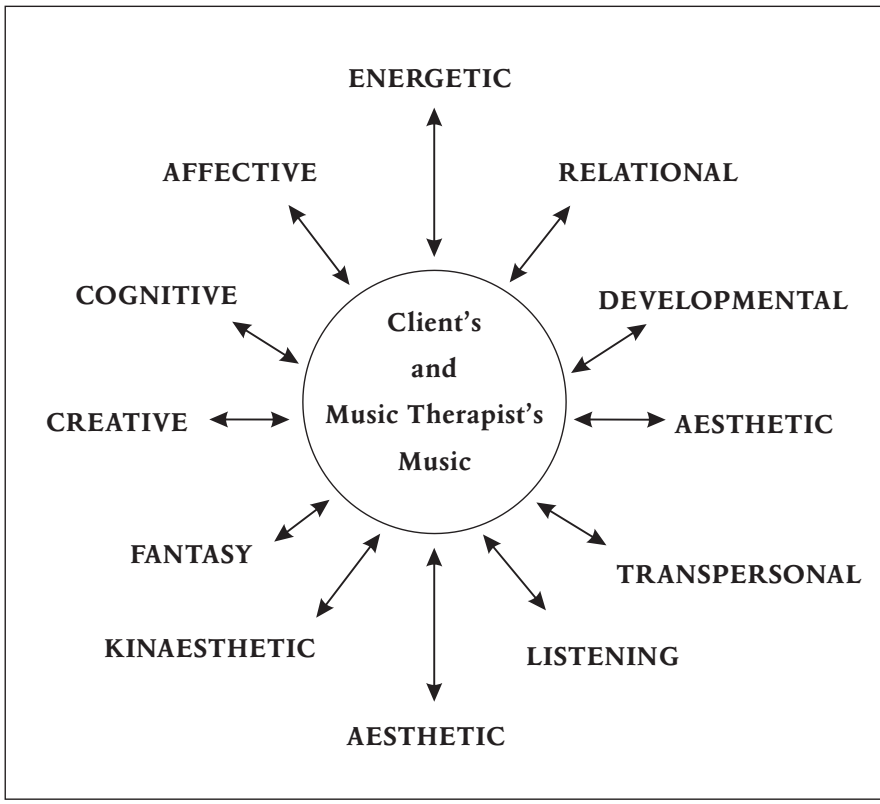

Figure 9.1 Listening categories involved in the process of deriving clinical data

In performing the assessment, the first step is to identify and describe the use of the following musical parameters:

- rhythm;
- melody;
- harmony;
- tempo;
- phrasing;
- themes;
- dynamics;
- choice and use of instruments/vocal.

Second, the following informational categories are identified in the music and described:

- *affective information*: emotional qualities, musical transference, musical countertransference, range of affect, self-esteem, dynamic variations;
- *relational information*: style of interacting, intrapersonal communication, interpersonal communication, awareness of self and others, willingness to interact;
- *cognitive information*: level of organization, structural components, ability to concentrate;
- *developmental information*: ego-function, drives, differentiation between self and other, dependence/independence issues, authenticity, level of integration/chaos/dissociation, ability to separate;
- *music released fantasies and images*: images, symbols reflecting significant experiences in past and present;
- *transpersonal information*: spiritual quality, meditative quality, altered state of consciousness;
- *aesthetic information*: quality of beauty;
- *kinaesthetic information*: body expressions, body flow, body energy, body tension/release during music, body temperature, body movements, body rhythms, body consciousness, body control, body language, body resistance, body interaction, body connection, body colour, body resonance;
- *creativity information*: absence/presence of ideas that develop, playfulness, ability to experiment and take risks, ability to symbolize;
- *energetic information*: absence/presence of flow, intentionality, high/low amount of energy.

In writing up the final assessment, the information derived from the music is combined with the following other sources:

- possible verbal information before, during and after music;
- diagnosis;
- client history;
- cultural context;
- processed themes or issues;
- previous sessions (if it is not the first assessment session);
- treatment goals expressed by the client.

All of these areas taken together provide an accurate assessment upon which goals and objectives are based. Furthermore, the client's own verbal and nonverbal comments in relation to the music must take priority in the process of assessment. With nonverbal clients the obvious primary goals are to recover speech functions, to develop additional communication channels, and to help to express emotions and needs.

Case study

Through this case study I hope to convey some of the problems and issues that the music therapist encounters working with and assessing a client who is physically traumatized in the context of a hospital.

Session one

History

Joshua was a 50-year-old accomplished composer, conductor and percussionist. He had a stroke caused by a lesion in the right basal ganglia. The stroke left him paralyzed on the left side of his body with mild left facial weakness and slight alteration of speech. Prior to his stroke he suffered from labile hypertension, but there were no other medical issues. I asked him how he had felt just before the stroke happened and he answered that he slept three hours a night and worked like crazy the rest of the time. He was conducting orchestras nationally and internationally and composing. He was in crisis economically. He had been married for about 20 years, but for the last two years the relationship seemed to be in a crisis. So the stroke came at a time that was particularly stressful.

Initial contact

I initially received a phone call from the client, who was in the process of recovery at another well known treatment facility. He was referred to me by a music therapist there. At that treatment facility there was no music therapy for adults. He expressed interest in receiving music therapy, wanted to know what it was, and whether there was a possibility of receiving it if he was transferred to the facility I was working at. As I referred him to our intake department I noticed that his voice had a flat affect and that he seemed very depressed. He seemed well functioning cognitively and beneath the depressed voice there seemed to be a strong will and spirit. When I mentioned that atonal improvisations were a part of music therapy he shared with me that he had visited Stockhausen in his home and that he had composed and performed music that related to him. He also mentioned that he desperately needed to get back to normal functioning because he had contracts for conducting orchestras to fulfil and that he intended to apply for a full-time job. When he talked about his music he seemed very alive and energetic. Personally, at that point I felt a good connection with him and had positive expectations of the work to come. I even took my Stockhausen music box with music from the composition *Tierkreis* with me with the thought that playing and listening to this music together as a ritual may make him feel 'at home' and heard.

A few days later I received a phone call from the social worker saying that the client had arrived. I went up to the unit for short-term rehabilitation with the Stockhausen music box in my hand, and sure enough there he was, lying in bed surrounded by a nurse, nurse's aid, physician, physiotherapist, and a family member. He was in good spirits and seemed to enjoy all the attention. I welcomed him and handed him the music box to listen to. He seemed delighted. I left the music box for him to borrow (transitional object) and we set up a session time for the following day. I already felt as if I was being magnetically pulled into the field of the client, a feeling akin to that of a musician waiting for the conductor to come. This feeling confirmed what was later happening with all staff that became involved with the client. He seemed to be able to orchestrate getting extra time and attention from everybody in the team including me. I extended myself by bringing some of my own instruments from my private practice into the music therapy studio in order to try to meet his

special needs as a musician and, especially, a percussionist. Among these instruments were Tibetan finger cymbals, a high quality symphonic cymbal, Tibetan gong bowls, a rain stick and a very big wooden block. I somehow felt unconsciously drawn into the work and was wondering if before the stroke he had the same affect on his surroundings. It is not an unknown phenomenon that unconscious behaviours and traumas that were already present in the client before the physical trauma are reinforced and activated when clients start treatment for the actual physical trauma.

Assessment

Joshua came 15 minutes late to the session, brought there by a student. The expression on his face was a mixture of being sad, but also little smiles and jokes would brighten up his face. He seemed very friendly, charming, sweet, warm, intense, polite, highly intelligent, and having the physical and mental presence of a young man. He had some undefinable charismatic qualities. He thanked me for bringing him the Stockhausen music box. He said it had made him feel less alone to listen to the music and more 'at home'.

Being late for the session became a pattern, something which could have meant several things:

1) scheduling problems;
2) memory problems;
3) fear or anxiety in relation to what might happen in the music therapy session;
4) time management problems;
5) an unconscious need to be waited for, just as everybody waits for the conductor to come and conduct the orchestra;
6) a way of getting extra attention;
7) an unconscious way of expressing stored up anger (message to therapist: this is how it feels when I am waiting for people to help me out).

With Joshua it showed up to be a combination of points 2, 5, 6 and 7. The client told me later on in treatment that after the stroke he often forgot what time it was. At that time I suggested that he put the alarm on his watch on, to alert him to when it was time for him to leave the unit

and get to the session. That did not help. When we started to work on his anger management, he slowly changed this pattern and was more often on time than late.

When I assess a client I try to do it in an improvisatory way, so that the client does not feel that he is being tested and run through a certain regimen. I go along with the flow of the session but make sure that I ask questions about goals.

Joshua expressed that he did not want to play instruments, just talk. It seemed as if a flood of words kept streaming from him without interruption, and I thought to myself, 'he must be very overwhelmed'. There were no pauses. When I suggested that we could play music together and use some of the verbal material as a starting point for an improvisation, he said he was not in the mood for playing. He was not happy with the instrument selection, saying, 'I am a percussionist. I have a different standard.' I showed him some of the electronic equipment that we had, including a sound beam, thinking that he had probably been working with electronic equipment in his compositions or in his conducting career. The sound beam works in such a way that a minor movement from a body part will be picked up by the beam and produce a sound. The sound beam can be connected to an electronic keyboard so a variation of instrumental sounds can be produced. He seemed to get more interested but no actual music happened in the session. 'I want to hear your music, your compositions', he said. I thought to myself that to play music for Joshua will be too overwhelming, because it would remind him too acutely of what he might have lost.

Resistance towards playing

It is a common phenomenon to encounter that the physically traumatized client does not want to play or sing. Often, one has to spend time working with the client about just leaving the room in order to get to the music therapy studio. Personally I think the resistance is related to several areas:

- fear that music, which for many people is emotion-laden, will open up areas of the psyche (open up to the trauma) that the client does not want to be confronted with;
- control issues 'I want to be in control – you cannot tell me what to do before I am ready for it';

- many people have not played or sung in an unfamiliar person's presence before so they feel performance anxiety;
- depressed clients often suffer from isolation, an absence of motivation, low energy, fear of changes, and a fear of letting things in, all of which can make them more depressed;
- issues of abandonment. The physically traumatized client often feels abandoned by their body. They have an unconscious need to abandon or act out what they feel has been done to them. So the client is indirectly abandoning the music therapist through his or her reluctance to play or sing.

I could empathize with Joshua about how traumatic it had been to realize that you could not use your hand, when your job is to conduct. I imagined that it must have touched upon a big issue of feeling out of control. His job was to be in control of a big group of people and here he is being a client in music therapy and working on gaining control of his life and body. Therefore I let him be in control in most of the session but made sure that I discussed with him what the immediate goals might be. He expressed that his biggest need was to regain mobility in his left arm and leg. He felt embarrassed about his body. He also said that he didn't want to give up on his left arm. He strongly believed that the mobility would return if he did not give up on it, 'I am determined to get my arm back before next summer!' He also mentioned that he had realized that he had lost the upper register of his voice, so perhaps I could help him with that. He complained that his brain was spinning and that he needed to relax. I addressed his emotional state and he said he was very depressed. One of his biggest fears was to be abandoned by his wife and also not to be able to work again.

Abandonment

Clients who experience severe physical trauma are often abandoned by their spouses, partners. It is simply too painful for the partners to see their loved one in such a condition. The abandonment might not happen right away, but after a while. So the fear that Joshua had was very realistic.

It is often also the case that the jobs that the clients had before they became sick do not stay available for them. When the job is closely connected to the

identity of the person, it must be even more threatening to live with the fear of losing your job.

Joshua made a joke about work: 'Who wants to hire a Frankenstein like me?'

I told him that we could work with all areas and see how far we could come. He told me that he would bring me tapes of concerts that he had conducted and music he had composed as soon as his wife could bring them. He wanted me to listen to his music and see him conduct. I thought that was a good idea so I could find out what his musical identity was before the stroke. He also told me that he used to get up at four o'clock in the morning to meditate. That gave me the idea that at some point we could do musical meditations if he wanted to and tap into his spiritual resources.

I mentioned to Joshua that I worked with a group of men who had had strokes, and perhaps he would want to come to this group if his schedule allowed for it.

I asked how he felt about audiotaping and possibly videotaping sessions. He said he was embarrassed about himself, but he would be willing to allow it if it could help the process. He signed a release form in the second session.

We had gone ten minutes overtime – I found myself struggling to stop the client – he did not seem to want to leave. I literally had to get up and open the door and push him out of the room. This repeated itself several times until I realized that the boundaries of this client were poorly established in this situation. His behaviour in the session reminded me of some of the narcissistic injured clients that I had been working with. It was obvious that he enjoyed my attention – 'See me, hear me, focus on me!' – and releasing in me as a music therapist a slight feeling of being used as an appendix in terms of relatedness. This is understandable in the sense that many big musicians, conductors, artists are narcissistic infused and make use of this condition to become great artists. In this case the narcissism did serve Joshua well in the sense that he got the staff to give him as much time as possible in physical rehabilitation, music therapy and occupational therapy, and constant stimulation which have been proven to be extremely important, particularly in the beginning stage after the stroke has happened. Narcissistic endured clients have a tremendous need of control and perfection. Therefore it

may be even more traumatic to experience loss of body control, on which they are so dependent.

Because no music was played or listened to I was only able to assess areas that did not depend upon music. I would have to wait and do ongoing assessment in the future sessions. In session two I was able to use recorded classical music and in session three I was able to improvise with the client. (See later additional assessment.) These are the areas that I could assess in the first session based upon listening to his voice and listening to the music behind his words:

Information based upon Vocal interaction:	
Dynamic:	Little variation in the dynamic. Most used dynamic: *piano.*
Melody:	The voice seemed limited in its use of melody. Had a monotone quality. This might be caused by stroke or depression or both.
Tempo:	Fast.
Information based upon Verbal interactions:	
Affective information:	Depressed, had some range of affect moving between depressed tone and some humorous comments. Low self-esteem about his ability to conduct and his body image. Emotionally overwhelmed. Abandonment issues.
Cognitive information:	Seems cognitively intact. There may be problems with short-term memory. Highly intelligent and educated person.
Kinaesthetic information:	Is able to use right side of body without problems. Left side is paralyzed. Is very focused on getting his left arm and hand back to life. Is not accepting his bodily condition as it is right now. Has a negative body image at the moment (Frankenstein comment). Low energy flow in body in general.

Transpersonal information:	Has a resource in his spirituality. Has used meditation as a daily practice. Is strongly identifying with the music of Stockhausen (where music is known for having strong components of spirituality combined with atonal language).
Energetic information:	Seems to have a huge amount of mental energy and a fast mental tempo.
Developmental information:	Seems to relate to me both as an adult and as a depressed child, who wants me to be his mother.
Relational information:	One part of me feels as if Joshua is relating to me as a conductor who is conducting his musician. Another part of me feels that he is genuinely interested in getting to know who I am. He makes me interested and excited about working with him – almost like a magnetic effect.
Aesthetic information:	Is highly conscious about the aesthetic aspect of music, qualities of instruments and amount of variety in instrument availability.

The rest of the areas (listening, creativity, fantasy, musical parameters) I could not assess without playing together with him.

Session two

Preparing myself for the session, I brought in a piece of recorded classical music: G.B. Pergolesi's (1710–1736) *Stabat Mater* – a religious work for voices and orchestra composed and completed a few days before the composer's death. I was thinking of offering the oppportunity for Joshua to listen and possibly conduct the first two very short sections of the music. The music in general is characterized by being highly structured and carrying an intense passion, often with a tinge of sadness. The first section is written in a minor mode, slow tempo, a sombre mood, with an emotional appeal in the vocal part of sadness and carrying the text (translated from Latin):

At the cross her station keeping
stood the mornful mother weeping,
close to Jesus to the last.

It is reflecting the passion from the viewpoint of the Virgin Mary in relation to the death of Jesus. Maybe it could match the mood and experience of physical and psychological 'death' that Joshua seemed to go through.

The second section has a quicker tempo, highly energetic movements, maybe appealing more to action and a forward direction, and the emotional quality seems to have changed to a more up-beat appeal. The text says (translated from Latin):

Through her heart, his sorrow sharing,
all his bitter anguish bearing,
now at length the sword has passed.

The quicker more energetic tempo with an up-beat appeal might help Joshua in terms of picking up the conducting and starting to make use of the healthy arm and hand.

Joshua was again late for the session, and I addressed the problem. He apologized and said that it was hard for him to manage time – everything took much longer than usual. He looked as if he was in a lot of emotional pain. He vented his frustrations about having problems adapting to being at a hospital, and mentioned again his concerns about his wife abandoning him. I listened and addressed the abandoning issue related to his left arm. I suggested that we used classical music to get him started, using his right arm and hand and picking up on his conducting skills. Maybe he could find a way of compensating, so that he could still conduct. (Today he is back conducting an orchestra and teaching!) This was a way to instill hope, which is an important factor in the process of healing. I offered to give his left arm and hand massage at the same time to see if the tonus of the hand could be relaxed, so the hand could be stretched out.

Using composed music to melt the resistance

When a physically traumatized person shies away from actively playing/singing music, which I have often encountered, it can be helpful to use

composed music that the client can relate to. The client sitting in a wheelchair has often become used to being helped and being served, because they are physically limited in their movements. This can lead to a pacified state of mind. In the beginning of the treatment the person can listen to the music with the music therapist and process it verbally afterwards. The client can also move bodily to the music. The music therapist can play recordings or produce the music her- or himself. This can often serve as a bridge to engage in music making later on.

> Joshua accepted this suggestion and when the music started, he closed his eyes and eagerly conducted to the music for twenty minutes. During the music I worked on the left hand. It got stretched out and we both noticed tiny movements in the fingertips. In the verbal part afterwards Joshua seemed to be more turned on to the process of using music as a healing tool. I was careful not to address his depression and just let the music do the job of holding, empathizing, connecting and structuring.
>
> The fact that I had picked that Stabat Mater was not by accident. I see this work as, in transpersonal terms, centred on death and rebirth. Something died (body parts) and something new is given life. A Stabat Mater is centred on the issue of death and originally was meant to be sung as a part of a Mass when somebody dies. At the end of the session I could see that Joshua was holding back tears. I mentioned to him that this was the right place to let go of tears, anger and whatever was stored up inside. He was not able to let go of the tears but seemed in a little better mood at the end of this session. I encouraged him to start meditating again and also to bring dreams with him to the sessions, if he could remember them. He asked if he could have music therapy twice a week, which I confirmed was a possibility. It seemed as if he was developing a positive transference to the music therapy.

Session three

> In this session, for the first time I had the possibility of assessing Joshua from his musical expression and processing abilities. We improvised twice. I have transcribed most of the session, because I feel that it gives a clear picture of where Joshua stood with himself bodily, mentally, and spiritually. It also gave me a clear picture of assessment based on his music.

Joshua still looked depressed and frustrated when he came in in a wheelchair and placed himself in front of the sound beam that I had taken out, and next to a big marching drum and a cymbal. I handed him a mallet and showed him also some Tibetan gong bowls that I had brought in from home. In this way I felt that I had acknowledged that maybe the instrument selection was not up to his standard, but I was willing to bring in instruments and mallets from home to make him feel heard. He picked up the mallet right away and fixed it in his left paralyzed hand. He then started to move his right arm to control the sound of the soundbeam, and it looked as if he was playing with the sound for a while. Then he stopped and said that he would like to invite one of his students in to the session. Perhaps the insrumental set-up in the music therapy studio reminded him of the time when he was formerly teaching his students. However, I did not react to his expressed wish, but tried to bring him to the here and now by asking him:

'Where are you now?'

He replied, 'I am not on sleeping pills any more – my dreams are more vivid now.' Joshua then reported on three dreams that he had had. One was about conducting an orchestra, and the audience made fun of the music and interrupted it. 'I must be in touch with some anger these days.' The second dream was about him finding himself swimming in the Mediterranean Sea. 'It was such an incredible feeling – the ocean was so extraordinarily beautiful.' The third dream was about a very good friend, who came to visit him. Joshua had a very close relationship with this friend, so it meant a lot to him. He mentioned that 'the pills shut off my mind'.

Personally I thought that a connection to the unconscious had opened up, and I felt that this was a very positive sign. I asked him if he wanted to use the dreams for some music. His answer was 'I want to hear more of your music' (still resistant). He then reported that he had seen the neurologist, who had strongly encouraged him to start using his right arm and hand. He said that he was willing to try it, but he also expressed his fears about not getting the movement in his left hand back, if he gave up upon trying to get it to move, saying, 'I love my left hand.' I strongly encouraged him to use both hands and said: 'Sometimes one has to ride on two horses at the same time.' He answered: 'Have you tried that?' I said 'Only in my imagination!' and we both laughed. I asked him for a title for the music and he said, 'I am in a watery mood – the ocean'.

Joshua experimented with the sound of the ocean drum, using the mallet that I handed him, and he also played around with the high registered glasslike sound that came from the sound beam attached to a keyboard. He started moving his left arm and hand in front of the sound beam, holding the arm with his right hand. It produced fast moving, short atonal tone rows – kind of eerie sounds with pauses in between, almost ghostlike. It made me think about a person in inner pain. I accompanied by playing on the piano a very deep note held with a pedal in the bottom of the register at the same time as I played clusters of the same tones as the sound beam tones in the high register in an interactive way, so one could hear that there was a connection between the sound beam notes and my notes. The fact that there was such a big empty space between the bottom and the top register reflected from my side my perception of Joshua's emotional state of mind. Depressed (bottom) but at the same time connected to a creative place with light, inspiration, and spiritual power (high register). I hoped to transmit the feeling that he was being heard through playing the same tones as he played in the clusters. As I looked at Joshua during the music I noticed that he carefully picked out the sounds that he wanted, and it gave me an impression that he gave high priority to the aesthetics of the music. The long pauses in between Joshua's tones seemed to be there intentionally. I interpreted it as something positive – Joshua took time to sit with the tones and expressed feelings, and not skate away from the pain, as he had before, when he spoke without pauses. Joshua played the cymbal for a short while in a very variable way, and then made a few deep single sounds on the big drum. Then he picked up the big ocean drum and moved it in a variety of ways – slowly, fast, from side to side. I accompanied with glissandi on the piano, going up and down the registers very fast and using the pedal to hold the sound. Sometimes it sounded like ocean waves, sometimes it sounded like big sudden crashes. This made me think about sudden outbreaks of anger. He experimented with using the thumb to make a sliding sound on the skin. Then he started playing fast rhythms on the outer part of the big marching drum and I started playing with these rhythms, knocking at the wood of the piano. It led to a passage with very loud banging on the drum and cymbal, which I accompanied with loud dramatic dissonances. To me it felt as if something was catching up with us or coming to a big dramatic clash. Then Joshua changed to work with the sound beam, experimenting with

movement and sounds. It looked as if Joshua was not content with the outcome of this last part, and he stopped. He made a comment about how frustrating it was not to be able to use his left hand – 'I just need to create the proper sound'.

I paid attention to the fact that Joshua did not talk about the content of the music, but focused on criticizing himself. The sound was not 'proper' in his ears. This seemed to me to reflect that we may have touched upon some sort of possibly self-destructive anger.

Right after this he mentioned that he was now able to stand up in physiotherapy and had started to try to walk with a cane. He was very content about this, saying, 'and I need to stand.' So I encouraged him to bring the cane with him to our next session, so he could practise standing for some of the time. 'That would be great!' he said. Then he yawned. 'I am sorry, it is the neurontin. It is a great painkiller, but it makes me so tired. I cannot quite control it.' I replied that I yawn a lot together with my clients, and that I consider it very healthy in terms of relaxing and letting go. I asked Joshua if he was now able to let things go, which we had talked about in the former sessions. Joshua said, 'Yes, absolutely. You have touched such deep areas of my psyche. A lot of emotional stuff that I am letting go of,' followed by a long pause.

'In which way?', I asked

'It expresses itself in such a way that I just start crying or very easily get in touch with my anger. The weekends are very good for that – I get so frustrated and very sad. My mind just spins out of control.' He cried silently. 'If it starts in an angry place, it will spin in an angry place and if it starts in a sad place, it will spin in a sad place.'

A stroke is often accompanied by overwhelming sadness and anger

Joshua is describing a very common phenomenon among stroke victims specifically. Therefore, when I see these emotions appear, I always focus on finding a way for the client to work on managing these emotions. I have created a 'men's stroke group' and a 'women's stroke group', where we use improvised music to deal with all the issues that arise from having had a stroke. We work in depth with the issues and emotions, and music seems to open up access to express, process and manage these emotions.

Benedikte: 'I was wondering if you would want to work a little bit with your anger, possibly on this big drum, to get some of the frustration out?'

Joshua: 'I could! I am just not used to being so programmatic. But I will be happy to try it.'

Benedikte: (encouraging) 'See what happens.'

Fear of trying something new

What I often encounter in my work with physically traumatized clients is a tendency to hang on to the old identity and to the familiar pattern of being. It seems to be a natural reaction to a situation where one's body and psychological condition has changed so dramatically so fast. Joshua expresses here that he is not used to improvising in a programmatic way. He is not alone in this. Most clients have never made programmatic music before. They may have listened to music or possibly played an instrument or sung in chorus. Therefore it is a big step to ask for them to improvise and to use programmatic content such as 'anger'. Even for Joshua, who did have some experience in improvising, it is a big step. If the client is able to make the step of starting to improvise musically, they have already started to work on the ability to improvise as a general life approach, which may be particularly helpful in a situation where nothing is the same as before the trauma. If the client is able also to make the step of using verbal content as programmatic material for the improvisation, and possibly process the improvisation verbally afterwards, the client has already come very far in the process of recovery. He or she will need the skill of improvising in general and verbal processing in their future daily life. Therefore I made use of this intervention with Joshua.

Joshua added in the same breath: 'Maybe I am turning the anger towards myself – there is a good possibility of that. Without my left hand I am only doing half a job. But I am doing what I can do.'

I said, 'Yes, you are doing the best you can do, and it is important to accept that, I think.'

'Expressing my anger'

Joshua requested a handful of different mallets, and when I handed them to him, he said: 'You may be getting me back to playing percussion again.'

I said, 'Yes, you may be able to look at it from a different point of view now. See if you can contact the place from where the anger comes.'

'I need two hands to do that, otherwise it is just mediocre. I want to release the spirit of the instrument. Do you want to join me?'

'If you want company, I will join you.'

'Sure I want company.'

The music started out very energetically and loud from Joshua, and it seemed to pull me in, although I would have liked to listen for a while (musical countertransference). We had a long phase of dialogical play, which turned into synchronized playing. The qualities of the music reminded me of a power struggle. The pulse became quicker and I suggested that Joshua use his voice also, an intervention in order to open up a vocal expression of the anger. Joshua did not follow up on that. I used my own voice as an instrument to try to encourage Joshua to release some anger. Something seemed to prevent Joshua from using his voice. Our music reminded me of music I had experienced when I participated in a sundance ritual with the Sioux Indians in South Dakota. Now Joshua changed the sound by hitting the outside of the drum, which produced big, deep sounds. After a while Joshua stopped. I felt disappointed, because I was enjoying improvising with him.

He said, 'I do not think that I am getting there!'

'What do you think is preventing you from getting there?' I replied.

'That I cannot use my left hand.'

'So it does not sound the way you want it to sound?'

'Yes!'

'Maybe we can find a way where you do not feel limited.'

'It is my limitation – I have to get around it.'

'It is time to finish – let us stop here.'

Joshua continued to talk as if he did not hear what I said. He talked about never having dealt with his anger in music, and about not being able to accept living with his limitation. 'I have not won the battle. If I accept it (limitation) I will never have use of my left hand back. I cannot accept that. If I push this thing through, then I have left something for my children and also given something to myself.' He continued talking for a while and I reminded him that it was time to finish. I also reminded him of the men's stroke group, but he said he could not make it with his schedule. Before he wheeled out he played playfully some rhythmic phrases on the drum as a kind of musical goodbye.

I was exhausted right after the session, and felt very challenged by him. I also felt excited by the fact that we could actually improvise

atonally together at a highly advanced level. The aesthetic component of the music as well as the spiritual part of the work attracted me. It seemed as if something important had been awakened in this session. Afterwards I wrote down my assessment and filled in the blanks that were left over from the first and second sessions.

Joshua's musical parameters

- *Rhythm*: Excellent sense of rhythm. Ability to play slow and fast rhythms. Ability to hold on to a rhythm. Ability to imitate rhythms. Ability to be playful and creative with rhythms.
- *Melody*: Good sense of instrumental melody. Able to play a melody, recognize, and repeat a melody.
- *Harmony*: Able to play tonal and atonal instrumental music.
- *Tempo*: Can be flexible in tempo. The most common tempo is a fast one.
- *Phrasing*: Is able to phrase. Stopped himself in both improvisations, before the music had a natural ending.
- *Themes*: No significant musical themes. Verbal themes of improvisations: 1) I am in a watery mood – the ocean. 2) expressing my anger.
- *Dynamics*: Is able to be flexible in dynamics. Had pauses in the music.
- *Choice and use of instruments*: Used big marching drum, cymbal, ocean drum, sound beam, and a variety of mallets. Was playing the instruments like a professional musician. Did not use the voice.
- *Affective information*: Depressed, has anger management issues (self-destructive anger), control issues, boundary issues, dependency issues. Musical transference: fear of letting go, need of being in control, need to be accompanied and listened to, low self-esteem in terms of body image, has survivor tools and resources (good sense of humour, charisma). Musical countertransference: a need to play together with Joshua, hard to keep own independence.
- *Relational information*: Good intrapersonal and interpersonal skills. Willingness to interact. Relatively good awareness of self and

others. There might be a tendency to use others as objects or appendices.

- *Cognitive information:* High level of organisation in music, cognitively almost intact despite possible short-term memory loss. Good ability to concentrate.
- *Developmental information:* Can differentiate between self and others. Has issues of dependence (difficulties in separating). Has trouble being authentic in the improvisation. This may be caused partly by Joshua's career as a musician and conductor. Ego-function is almost intact. Is a very driven person.
- *Music released fantasies and images*: None, but it is clear that Joshua has a good imagination. The potential is there.
- *Transpersonal information*: Joshua's music has a spiritual component and potential.
- *Aesthetic information*: Joshua is very aware of the aesthetic qualities of his music. His music has inherent aesthetic qualities.
- *Kinaesthetic information*: Joshua is using as much of his body as he possibly can at the moment. Is very expressive in his body language. Has low esteem in terms of body image. Is very active bodily. High amount of body energy.
- *Creativity information*: Is a very creative person and is using the instruments very creatively and playfully. Is willing to take risks.
- *Energetic information*: There is intentionality in Joshua's music and the presence of an energetic flow. There is a high amount of energy in the music.

Based upon the whole assessment I developed the following goals in my work with Joshua:

- relief of depression;
- moving from dependence to independence both psychologically and physically if possible (ability to move with cane, and move left arm);
- regaining of natural vocal range;
- improvement of boundaries;

- improvement of body self-esteem;
- tapping into spirituality as a resource;
- regulation of physical and mental energy;
- improvement of time management;
- improvement of authenticity in improvisations;
- improvement of relaxation skills;
- help Joshua to retrieve conducting and composing skills.

In the following sessions Joshua was able to use free improvised music in a variety of ways. In some sessions, we would do musical meditations with gong bowls and voice. In other sessions we would use dreams as the base for improvisations. In one session we listened together to one of his atonal compositions and, inspired by that, he started to compose again based upon the principles guided by mandalas. (The mandala is a cryptogram, a circular form, that symbolizes the unity of the world, universe and/or psyche. In drawing a mandala, a person can crystallize in colour and form an aspect of the self (see Jung 1973, in Ventre 1994, p.21).)

Joshua slowly got used to the idea of using free improvisations to identify what was going on inside. In between, Joshua had the need to listen to composed music in order to feel structure and holding. At the end of one session we integrated work on a computer, in order to determine whether Joshua could use the computer as a composition tool. He was able to use the computer as a writing tool, although he needed training in organization and spelling of words. The music therapeutic goals that I had set for Joshua were reached except the regaining of vocal range.

Within three months Joshua was able to recover slight movement in his left arm and movement in his left leg, so he was able to walk slowly with a cane. After he returned to his apartment he managed to get back to his career as a composer, conductor and teacher. We have, sporadically, been keeping in touch with each other over the telephone for the last three years. Out of my curiosity about getting to know from his perspective about his experiences with the music therapeutic improvisations and about his process, in June 2001 – 3 years after his music therapy treatment – I conducted an interview with him. This, among other

things, focused on how he perceived that the music therapy had been useful in his process of recovery.

Below, I have pulled out some interesting comments in relation to this article. As music therapists, we often assume what is/was the objective and subjective significant aspects of a treatment. I think it is extremely important for the field to receive information from the client's perspective.

> B: What were the important experiences for you in music therapy, what was significant for you?
>
> J: Going back to that first day. I arrived, I was taken off the journey and at that point I heard this music box playing the music of Karlheinz Stockhausen, and I thought: am I dead – have I arrived in Heaven already? By just hearing the Stockhausen – so close to my own aesthetic – I immediately felt some changes begin to occur in my bodily system, because I felt comfortable and relaxed. I knew I would have a therapist who would understand where I was coming from.

Here Joshua is talking about the importance for the music therapist to tap into the musical identity of the client immediately in order to help to facilitate a positive transference and a sense of connectedness. This was done here through composed music, but it could also have been done through improvisation (for example, in the style of reggae if the client was coming from a Jamaican culture). The other aspect, which is addressed here, is the area of musical aesthetics. Many clients have a consciousness about how 'their' music sounds, and to be able to play or sing 'their' music in an aesthetically correct style, either for or with them, may signal to the client that the music therapist knows who he or she is behind the physical handicap.

> J: So when I was working in music therapy with you we immediately started to improvise. You had some Tibetan finger cymbals, and those were quite beautiful because they began to stimulate their own structure within me.

Interestingly in the forefront of Joshua's memory stands the improvisation – he seems for some reason to have forgotten the beginning steps of the process consisting of not wanting to play and of listening and con-

ducting to classical music. So the improvisation as working medium seems to be the most powerful in his process.

He remembers the Tibetan finger cymbals, which are used for ritual purpose during meditation in Buddhist temples and are associated with spirituality. They appeal to Joshua's well developed sense of spirituality, which is a big resource for the potential of healing. Joshua describes the ability of the cymbal sounds to stimulate a structure inside him. I think that here Joshua is talking about the power of sounds and music to reach and stimulate healthy parts of one's self, that has a certain structure. It is important here to mention again the need of offering some kind of musical structure for clients with physical traumas. Certain body parts have lost their structure, and therefore the ego structure of the client must also be affected.

J: My physiological structure understood that there were blocks. Of course when you are paralyzed you feel that you have been given injections of Novocain in different parts of your body. I understood that if I could begin to remove those blocks of feeling that I would begin to move again. And that also would help my recovery. In that regard when we started to improvise and begin to use the Tibetan cymbals and some other things, because I was usually a percussionist, and of course composer and conductor, then we were working in a system of improvisation, that I felt very close to and very at home with.

B: Can you describe that system?

J: I can. Free improvisation.

B: And which type and qualities?

J: More meditative! Which was very important due to the fact that those blocks that I felt in my body, I felt were emotional blocks as well. So if I could begin to liberate the emotional energy that had blocked different parts of my system, then I would begin to move again. So that was a very important part of music therapy for me, because I am also an improviser and I believe very much in improvisation. Also the electronic – the keyboard improvisations with you – you also improvised with me both with percussion, keyboard and cello. Very important of course, because cello is the

> instrument of the Gods. And particularly when you play it, it was so beautiful, that I began to feel those blocks began to disappear. Therefore things began to loosen up in my system.

Here it seems like Joshua is describing how he felt that free meditative improvisation helped him and how he felt a spiritual connection between body and mind. I think, in a very unique way, he has captured the essence of the kind of work I have tried to describe different aspects of in this chapter. He also confirms my own personal experience, when I am improvising freely – a deep rooted feeling of being in a field of integration between body, mind and spirit. A little later in the interview Joshua expressed the integration in following words: 'It was the connectivity in the expressive self, the cognitive self and the physical self that was happening.'

In the part of the interview, where Joshua and I talked about the possible existence of archetypal forms in music, he mentioned something very interesting:

> J: That reminds me. I must tell you about this. In these days I have very, very powerful dreams and visions in my dreams. And one of the most important – because you mentioned archetypal – one of the most important archetypal visions has been that every now and then I am paid a visit by a very elderly Korean sage. A musician! A very wise elderly Korean man. Very wise. And when he comes to me in the dream – when he comes to me as an archetypal presence – he always brings a new instrument. And those instruments have the most incredible sound I have ever heard. Sometimes they are percussion, sometimes they are just bells. But this Korean wise man is like an Avatar. He always comes to me and plays these incredible sounds. And that happens fairly frequently. He plays for me and sometimes he gives me the instruments to play.
>
> B: So in a way the music therapy process is continuing in your dreams on an unconscious level.
>
> J: Yes, it is. Or more on a superconscious level.
>
> B: The process is continuing.
>
> J: Yes, it is continuing. Isn't that fascinating?

For readers who are interested in reading about stages in the treatment, session phases, and techniques, one can read about that in my 1999 article in *Music Therapy and Medicine* (see references).

Let me finish this chapter in the spirit of Karlheinz Stockhausen, whom I would like to quote:

> I even said that we should become the sound. If the sound moves upwards I also move upward; if it moves downwards, I go down too. If it becomes quieter, so do I. (Stockhausen 1989, p.67)

Stockhausen sees art as a reflection of life. I would like to follow up by saying: 'free improvisation is a reflection of life', and therefore a great tool for any music therapist to work with. Finally, I would like to share my deep gratitude for having been given the opportunity to work with Joshua and for being given the gift of him sharing his valuable experiences with the music therapy community and me.

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Part Three

CHAPTER 10

Supervision of Music Therapy Students in a Music Therapy Graduate Training Programme

Barbara Hesser

This paper was offered as part of a panel on the supervision of music therapy students at the Ninth World Congress of Music Therapy in Washington DC in November 1999. This panel was moderated by Dr Dorit Amir and in collaboration with Brynjulf Stige, Dr Denise Erdonmez Grocke, Nancy MacMasters, Sandra Brown. In this chapter I can only offer some key ideas that can perhaps be pursued in future dialogues in more depth.

The art of supervision

Music therapy is a challenging career and requires an ongoing process of growth. Therefore, clinical supervision should be a regular part of the life of all clinicians throughout their career. Supervision that is given to students during training is the beginning of this lifelong journey.

Supervision is a very important and challenging part of training students in music therapy. It is the supervisor who helps the student to integrate all her or his classroom learning into practice. I look at supervision as an 'art'. I speak of it this way to emphasize the artistic and improvisational aspect of how the supervisor uniquely offers her or his guidance to each individual student. The supervisory relationship is a creative relationship that needs to be skilfully built and requires careful timing and pacing throughout. Although supervision is aided by a great deal of music therapy clinical experience and knowledge from the supervisor, it is finally the 'art of supervision' that makes this process work for the student. As clinical supervisors we will need the skill to deal openly and honestly with the students as they go through the various stages of their

process. We will need to look deeply and honestly at ourselves and have our own avenues to deal with any countertransferences and blocks that occur in the process of the supervision.

As a profession, we have begun to focus more attention on the importance of supervision and to discuss many aspects of the supervisory relationship. However, I am concerned that we do not include in the discussion what area and level of clinical practice we are aiming for in our supervision. To discuss supervision based on models of music therapy (for example, Nordoff-Robbins) may be a beginning, but different models can be applied in different areas and levels of clinical practice. I feel that we must find a common language and understanding of areas and levels of practice in order more deeply and thoroughly to discuss either academic training programmes or supervision, during and after training. The philosophy and goals of training programmes differ around the world and I believe this will deeply affect the concept of supervision in any given programme. Different kinds of supervision may indeed be appropriate for different training goals. I think we will find both commonalities and differences in the role and tasks of the supervisor in different areas and levels of training and practice.

Areas of practice

I would like to make a case that the philosophy and goals of supervision are inextricably connected with the *area of music therapy* and the *level of practice* that is being taught to the student. The area of practice here refers to the primary clinical focus of the music therapy treatment and the level of practice refers to the type and depth of therapeutic change expected within that area of practice. To discuss the issues of supervision deeply and with common understanding, I believe it is necessary that we begin to specify clearly both the area and level of practice we are training our students for as a starting point and grounding for any discussion of supervision.

Music therapy as a profession in the US has grown rapidly over the years since its inception in the 1940s. Because of the large variety of clients that we treat and the many possible uses of music as or in therapy that have been developed over the years, our profession is naturally beginning to need to encourage specialization in both music therapy training and practice. It is encouraging that the uses of music in or as therapy have grown to such an extent that we need to organize and categorize them so that we can have a clear basis for dialogue in the field. However, confusion is caused in the discussion of

important issues in our field, such as training programmes or supervision, by the many different ways we are currently using to categorize the different types of music therapy practice, and the lack of common understanding. Some categorize by music therapy theorist (for example, Nordoff-Robbins, Priestley, and so on); treatment group (music therapy for psychiatric adults, and so on); music activity utilized (the use of improvisation in music therapy, and so on); or the psychological theory used as a basis for treatment (psychoanalytic music therapy, and so on).

Over the years, I have begun using a system that classifies music therapy approaches by the large area of clinical treatment focus, such as: music in medicine; music psychotherapy; music healing; and music in special education. These broad areas can incorporate the other kinds of classification within them. Each area can also be broken down into various levels of practice, although a detailed discussion of this goes well beyond the scope of this chapter. However, it is a much needed area for dialogue in our profession. I have taught, presented, and written about this subject for many years (Hesser 1980, 1985a, 1985b, 1988, 1991, 1995; Hesser and Pratt 1989) in an effort to clarify our way of looking at the profession. Ken Bruscia, in his important book *Defining Music Therapy* (1998), has addressed both areas and levels of practice.

Supervision is also guided by whether the student is gaining competencies at the entry or advanced level of practice. There is not yet an international agreement on the terms that we have used in training in the US. These two levels are addressing the depth and type of practice that the student is being prepared for during their training. Entry level training in the former American Association of Music Therapy (AAMT) led to certification as a music therapist and was based on achieving the entry level competencies for the practice of music therapy which were first adopted in 1975 and published in 1981. (Bruscia, Hesser and Boxill 1981). The newly unified American Music Therapy Association (AMTA) will vote this year on its standards document for education and clinical training (1999). This document proposes that all entry level music therapy education in the US be competency-based as specified in the *National Association for Music Therapy (NAMT) Professional Competencies* (NAMT 1996). This competency document incorporates the old AAMT document with some additional competencies. It is also recommended that advanced competencies be developed and that an advanced credential be explored by the Certification Board. This report also recommends that the organization articulate levels of practice for education and training programmes at the bachelor's, master's and doctoral degree levels.

The basic concept of entry level training involves gaining a broad understanding of the field of music therapy and learning to use music in a variety of ways with a variety of clinical populations. Today this is a big job. The number of clinical populations whom music therapists treat is expanding, and the theoretical and practical knowledge in the field is growing rapidly. This has led to the development of advanced training programmes that build on entry level skills and offer additional advanced competencies to the clinician. This training offers the students the ability to practise at another level of music therapy.

Supervision at New York University

Throughout the next part of the chapter, in order to speak more specifically about supervision, the New York University (NYU) training programme will be used as an example. The model of music therapy supervision that we use is based on the area and levels of practice that have been chosen for training. Although I have great respect for all areas of music therapy practice, I have found over the years that realistically I cannot prepare students for all areas of practice. Therefore, I now focus the entire graduate training programme on the area of practice I call *music psychotherapy*. Students interested in other areas of practice are encouraged to apply to training programmes that are better suited to their area of interest. In referring students it is helpful to me when other training programmes have articulated their area of focus.

Currently, certification in music therapy in the United States is at the entry level. This entry level training takes place in a bachelor's degree, a bachelor's equivalency programme, or an equivalency programme that is part of a master's programme. If the entry level training takes place at the master's level, additional advanced competencies are required beyond the entry level for completion of the degree. The NYU programme is a graduate training leading to a master's or doctoral degree. Students may enter the NYU programme at either the entry or advanced level based on whether there is previous music therapy training and certification and their level of demonstrated competency. Only students who will eventually complete the advanced level can be accepted into the master's programme since we do not offer a bachelor's equivalency programme. Student's programmes are individually tailored based on the competencies that are needed and each student will complete the programme in different lengths of time. The master's programme takes two to three years, and the doctorate three or more.

Over the years, I have also identified three levels of practice in music psychotherapy – supportive, re-educative and reconstructive (Hesser 1980) based on Lewis Wolberg's (1967) well-articulated levels of psychotherapy. My graduate programmes are designed around the *re-educative and reconstructive music psychotherapy* levels of practice. While all psychotherapy deals with problems of an emotional nature which manifest themselves in disturbances of thinking, feeling, behaving, and relating, re-educative music psychotherapy requires the student to work with the conscious issues of their clients, whereas reconstructive work is more involved with the unconscious issues and processes. The master's degree focuses on helping students achieve a re-educative level of music psychotherapy practice and the doctoral programme moves students toward a reconstructive level of practice.

Our master's programme provides students with an opportunity to specialize with one client population and to develop a re-educative music psychotherapy clinical approach for that population. The student either selects a re-educative music psychotherapy approach which is offered by one of our cooperating supervisors or they develop their own unique clinical approach. The doctoral programme begins to prepare students for reconstructive music psychotherapy practice and the students can select an approach that is offered or develop their own unique reconstructive clinical approach.

The programmes integrate academic coursework and clinical experience throughout. Our emphasis on music psychotherapy requires that the students become deeply involved in their own personal self-growth and gain an understanding of how their culture, personality, music and theoretical points of view all affect their clinical treatment. Specific music psychotherapy approaches such as Nordoff-Robbins and Guided Imagery and Music (GIM) have their own additional personal therapy and supervision requirements specified by their national organizations for completion of the training. These additional certification requirements can be completed in conjunction with or after the degree requirements are met.

Clinical training and supervision is an extremely important part of the NYU music therapy graduate training programmes. Because it is beyond the scope of this chapter to write about both levels of training, I will concentrate only on the master's degree goal of re-educative music psychotherapy. Throughout the entire training, students are in clinical settings such as special schools, hospitals, and clinics, working with clients who are dealing with a wide range of mental,

physical and emotional and spiritual problems. It is in these settings that the student puts into practice everything that he or she is learning in the classroom.

There is close clinical supervision during each step of our programme, although the purposes and tasks of supervision will vary depending on the stage of development of the student. The clinical training is developmental and the amount of time spent, the amount of clinical responsibility for clients, and the music therapy competencies learned expand and change throughout the programme. In the first year the students are in two different placements, one with children or adolescents and one with adults or the elderly. We call this yearlong training 'fieldwork' and it is designed to offer entry level clinical competencies with two different populations. Students are taught to assess clients, plan and carry out music therapy treatment, and evaluate this process. The student is also encouraged to develop flexible musical skills and to carry out different music therapy techniques.

In the second year all students have one clinical placement for the entire year. This culminating experience is called 'internship' and is selected based on the student's area of clinical specialization. The students are meant to solidify their entry level competencies and begin to develop their advanced competencies. The students develop a theoretical framework and context for their treatment that includes an in-depth understanding of the dynamics and processes of individual and group music therapy for this population.

During each experience, the student has an on-site music therapy clinical supervisor at the facility where they are practising, and an academic music therapy supervisor who meets with them weekly in a small seminar, visits them four times a year on-site, and collaborates with the on-site music therapy supervisor throughout the process. The academic supervisor is an experienced supervisor with on-site supervision experience who can be very helpful to both student and supervisor during the process.

The entire clinical training process is coordinated by the student's programme adviser and includes the academic supervisor, all music therapy professors who work with the student in classes, and the music therapy group leader. The team assists the students in integrating their knowledge from coursework, personal growth experiences and clinical experiences. Communication between all faculties involved throughout the training maximizes the student's experience.

Stages of development in supervision

The internship process develops in two stages. The first stage is a completion and deepening of entry level competencies. In the first stage the student, no matter how experienced, is adjusting to a new clinical setting, to working on a day-to-day basis with these particular clients, to learning their needs, and the specific goals and objectives for this population. The student is also learning how music can be used to address these treatment needs, and learning to run music therapy groups and individual sessions. This stage is usually not more than a semester, based on previous life experience and the courses and field experiences in the first year of the programme. The student has selected a supervisor who works in a way that is compatible to how they would like their work to become, and in this first stage the intern 'tries on' the music psychotherapy approach of the supervisor. The clinical approaches of some supervisors are more fully developed than others, with more information and knowledge to impart before the students will begin to develop their own unique way within the approach. This stage also requires that the supervisor helps the student to integrate into practice the knowledge gained from the training up to this point.

Stage two begins when the student is comfortable working with the approach of the supervisor and running group and individual sessions. The student will now begin to evolve a personalized style of music therapy based on the level of therapy that is appropriate for the client population they have selected, their growing theoretical framework, their musical gifts, and their natural personality. The goal of advanced level music therapy training is to synthesize theoretical knowledge, self-growth experiences, and clinical techniques into a deeper level of music psychotherapy practice. All coursework is coordinated to assist the student in this process. Clinical improvisation and music therapy theory classes during this year assist the students in identifying and articulating their own emerging approach to music therapy. In this stage the student expands her or his ability to work with clients on a re-educative level.

The supervisor's role is to assist the students in developing their own individualized approach to the work. Supervisors need to allow the student to disagree with aspects of their work as part of the process of developing their own way. Letting the intern go and allowing a student to grow beyond us can sometimes be a difficult part of the training process.

Supervision at this stage is designed to help the students expand their understanding and awareness of themselves as music therapists, and to learn

how who they are impacts the therapy. This stage requires the supervisor to take more of a facilitator role in helping the student identify what personal issues need to be addressed in order to allow the clinical work most fully to develop. Personal issues and any countertransference that arises in the client treatment, as well as any issues that arise in the supervisory relationship itself, are pointed out. It is very useful at this stage if the students have their own individual music or verbal psychotherapy where they can take these issues and explore them more fully.

The role of the supervisor

I believe the supervisor walks a middle road between the more clearly defined roles of a teacher and therapist. Elements of both roles are necessary in the music psychotherapy supervisor's work. Communicating the skills and knowledge of being a music therapy clinician requires the skill of a teacher, while helping to identify the student's personal growth issues requires the knowledge of a therapist.

Some supervisors have difficulty finding a balance between these two functions as they develop their relationship with the student, and it is an art to move fluidly between these two roles. Some stages of the training process may require one function more than another, although elements of both are always needed. For example, in the first stage of development when the student is new to the placement and approach of the supervisor he or she can often be assisted more through instruction and teaching. Later, in the second stage of development when the student has developed her or his way of working in the specialization, he or she may need more help in identifying the personal issues that are coming up that block the therapeutic process of the client.

Some of the important teaching aspects include communicating the theory and method of the music therapy approach and the skills of how to use music in this approach. Helping the student to get an in-depth understanding of the client's strengths and needs in treatment, and how the particular institution they work in affects the treatment is also important. The supervisor at this point uses the tools of demonstration, observation and verbal, musical and written processing. Ideally, the on-site supervisor will demonstrate her or his work for the student. The student has a chance to observe someone working with clients on an ongoing basis. The work is then discussed in both a practical and a theoretical way. The supervisor also observes the student working with the clients and gives feedback.

There are also many opportunities for verbal, musical and written processing of the experience. We ask students to keep written analytical and personal logs that are read and discussed with the supervisor. It is our belief that it is important to use music in supervision as much as possible, to allow the student to experience what they are putting into practice. In the role of a teacher the supervisor can work together musically with the student to allow her or him to experience the various musical activities that are used and to explore clinical improvisation techniques. The supervisor will help a student build appropriate repertoire and expand music skills for clinical work. Tape analysis (audio and video) of the music used in sessions can explore the deeper use of music as therapy. The internship training time when the student needs to integrate all of the learning that he or she has received to this point can, understandably, be stressful. The supervisor needs the skill to present the learning challenges sequentially without overwhelming the student, finding the right proportion of support and critique. The timing and pacing of the learning is vital.

The supervisor also needs to bring her or his full therapy skills to the relationship with the student. In music psychotherapy our clients use music and words to explore their conscious and unconscious processes. It is difficult to guide others in their development if we have not experienced the process ourselves. Therefore, it is important to help students understand how they personally effect the ongoing therapy process (countertransference). In our approach the supervisors will not fully work through the students' psychological issues that arise. Rather they will help students recognize what personal issues are coming up in sessions. Most kinds of psychotherapy deal with the relationship between the therapist and the client and common patterns of relating will evidence themselves throughout the supervisory relationship. Therefore, in-depth analysis of the supervisory relationship can offer important insights into the clinical process. Exploring these issues can be done both verbally and musically.

Music can play a big role in the supervision in this stage of the training. The supervisor can assist in helping the student experience her or his clinical approach first hand in supervision through musical role play. Music can be used to explore and work through issues that arise during the clinical work and can be used in the relationship between supervisor and student for connection and/or exploring issues in the supervisory relationship.

The supervisors need to evaluate the student at the end of the internship process and, because of this mixed role of teacher and therapist, there is a boundary that all our supervisors keep in dealing with students' personal issues.

There is a delicate balance of how far to go at any given time in helping a student work with the personal issues that arise in the process of clinical training. This calls on the sensitivity and artistry of the supervisor. It is suggested that the student work through these issues in more depth in her or his own private personal music or verbal psychotherapy.

It is my belief that the student needs to experience a re-educative music psychotherapy in order to work successfully with clients at this level or a reconstructive music psychotherapy if they are working at this level of practice. Some of this can to be done during the training programme through re-educative music therapy groups that all students participate in, although additional private music or verbal psychotherapy is recommended. It may take time to develop a local group of music therapists who can provide this for students on a private basis. Our field is just now beginning to produce professionals capable of working on these levels of practice. Verbal psychotherapy can also assist the students in their development if music therapy at this level is not available.

Conclusion

The example of the NYU supervision process has been used throughout this chapter to offer one illustration of adapting the supervision process to the area and levels of practice that are sought in the training programme. I believe that different areas and levels of practice will require the supervision to be different. In a music psychotherapy training process the supervisor functions as both a teacher and therapist. The training consists of two stages and therefore will require different functions and combinations of functions at both stages.

The supervision process during training helps the students move from reliance and dependency on the supervisor in the beginning to independence and readiness to take their place in the professional world. A good supervisor at this critical time of learning can help the new professional to understand the purpose of ongoing supervision throughout her or his entire career.

Supervision is certainly an exciting and challenging experience for the supervisor. There is much to learn from supervising students at this very important time of their professional development. The art of supervision is to find a balance between offering the student skills and knowledge to practise music therapy and guiding their personal growth and development throughout the process. Our supervisors report how much the process has helped them to articulate and improve their own clinical work.

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CHAPTER 11

Self-Experience for Music Therapy Students

Experiential Training in Music Therapy as a Methodology – A Mandatory Part of the Music Therapy Programme at Aalborg University

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Introduction

As a pre-experience for clinical work, students on the music therapy programme at Aalborg University, Denmark, are, over four years, placed in the role of 'student-clients' as a preparation to work with music therapy from a psychotherapeutical base with many different client populations. Overall, this part of the training programme is called experiential training in music therapy (ETMT), and the music therapy teachers working in this area are called experiential training music therapy teachers (ETMT teachers).

The basic method of ETMT in this programme is improvisational music therapy as developed primarily by Mary Priestley in her model of Analytical Music Therapy (AMT). (Priestley 1975, 1994). This model has been further developed and adapted as one basic approach for the programme at Aalborg University. This programme offers a five-year, full-time master's (MA) degree in music therapy. In addition, a three- to six-year international PhD programme is run in the music therapy department, and a music therapy clinic was established in 1994 at the Aalborg Psychiatric Hospital as a centre for treatment and research.

Important elements in the five-year training programme are:

- *musical skills* – musical and clinical approach to vocal, instrumental and keyboard improvisation. Musical repertoire;

- *self experience* – individual and group training in the therapy process;
- *didactics and methodology* – theory and practice including practicum placements with different client populations;
- *theoretical knowledge* – psychology of music; general and clinical psychology; psychiatry; theory of science and therapy; theory of music therapy.

A comprehensive entrance test includes instrumental and vocal skills, improvisational skills and talents, and a personal interview: 12–15 of over 40 applicants are admitted every year, giving a total of 50–60 students enrolled in the programme over all five years. The programme qualifies music therapists with both a scientific and practical foundation, who are then equipped to undertake clinical treatment and consultative work independently, or within a team.

Experiential training in music therapy

Originally, the idea of offering ETMT to music therapy students was developed by Mary Priestley in the early seventies. She offered individual music therapy and Intertherapy (IMT) (see below) as a supplementary private training to students from different music therapy training courses.

No training programmes had self-experience disciplines integrated or added to their programme at that time and the idea was perceived as rather controversial by most music therapists although some spotted its potential.

> The Intertherapy training was a useful opportunity for students who wanted to work in music therapy with clients with complex psychological problems. (Pedersen and Scheiby 1999, p.59)

Johannes Eschen from Germany was in the first student pair in the IMT training by M. Priestley:

> After having finished the IMT training Eschen tried out self-experience training parts (individual and group music therapy and IMT) with clients and special education students in Hamburg before he managed, as the first trainer, to integrate self-experience as a mandatory part of the two-year full-time training programme: *Mentorenkurs Herdecke* in Herdecke, Germany, 1978–80. (Pedersen and Scheiby 1999, p.60)

I have transferred those experiments to the programme that I found in Aalborg and I further developed the ETMT into a five-year programme model, together

with my former colleague, Benedikte B. Scheiby, in the eighties. We emphasize group music therapy and individual music therapy, the only two disciplines where the students are in a pure student/client position, as a basic training in the first two years of the programme that runs concurrently with a basic training in musical skills and theoretical knowledge. The ETMT training has an equally important role in the basic training before the students move into methodology and clinical practice training in the third, fourth and fifth years of training.

The overall aims of this training are as follows:

- to increase the sensitivity and flexibility of the students' ability for establishing contact and communication through therapeutic musical experiences
- to explore traumatic blocks, and to develop more personal insight and resources through therapeutic musical experiences
- to develop musical techniques to work with transference and countertransference issues
- to develop musical techniques to listen to, and to be in a fluent relationship with, body, feelings and consciousness
- generally to develop musical techniques to establish and develop contact with clients at different levels.

Therefore the ETMT is designed to emphasize the artistic and 'sensitivity' training of the students, to make them aware of themselves as the resonating tool for music therapy work, and from there to build bridges to their consciousness about methodological possibilities with different client populations. Knowledge is acquired about the connection between their way of understanding people, music, health, and therapy, and their theoretical foundation and choice of method.

Why experiential training?

Whatever method you use in music therapy, a basic tool is your own presence and mental preparedness as a therapist. Sensitive and clear musical and verbal communication with clients is another fundamental requirement. ETMT offers training in learning not only to listen in order to analyse the client or the client's music, but also to listen to oneself listening to the client.

This experiential training focuses on the presence and function of the music therapist being with clients, and can be seen as a basic training for all music therapists irrespective of the area in which they are working.

The training is very complex, as it has to be done with a clear understanding of the double character of mental resources and preparedness, and how these are experienced and expressed through music. These are, on the one hand, a consequence of a person's life story and actual social circumstances, and, on the other hand, they are genetically cognitive and emotional fundamentals, with which a person selects, perceives and influences her or his circumstances.

It can be a vulnerable area to work in because of the vital nature of these processes. Exploring your life's experiences and the way you function, some of which you might not find practical or may find limiting, can be experienced as threatening and anxiety provoking. So clear ethical rules and a respectful understanding of the processes involved in the training are necessary.

One could argue whether such training disciplines should be part of a music therapy training programme or if they should be a kind of personal therapy each student undertakes outside the programme (mandatorily or by personal choice), where there would be no relationship between the individual therapist and the programme. I have heard different arguments for and against.

The most common argument against having ETMT integrated in a programme is that the private life of the students should not be invaded. To this statement I can say that after having been part of such an integrated training programme for eighteen years, and having been the contact person for the ETMT track in the programme and responsible for taking care of ethical and other problems, I have never encountered this problem. On the contrary, most students who apply for the entrance test claim that they want to enter this programme precisely because of this integrated model. One problem that I did encounter was when an ETMT teacher evaluated that a student would benefit very much from further personal therapy while the student did not consider this necessary. No student can ever be forced to undertake more therapy – according to ethical rules they can only be advised and we can try to advise them in the best possible way knowing that the student might know better her- or himself. Often, students being recommended to undertake further individual therapy only realise the necessity when they come into practice, or later into clinical work. In such cases the ETMT has had the function of identifying and clarifying the issues that need further exploration and personal work.

I often listen to students expressing that they very much appreciate that the programme takes their personal development as seriously as other parts of their professional development.

Another argument I have encountered against having ETMT as a mandatory part of a programme is that teachers other than ETMT teachers can rather quickly identify issues such as weak borders, extreme anxiety problems, low motivation, or lack of self-reflection, and so on. I think this is absolutely right, and that the evaluation and examination process may be influenced or coloured by teachers knowing about these issues. They may let the student's personality patterns influence their evaluation of the student's body of knowledge or technical skills without externalising what they are really evaluating.

In the integrative training we try to be clear with the student in openly addressing what is the function of the different situations and then to help the students themselves to reflect on how personality issues might influence how they present themselves, relate to others, and so on.

One could ask if students who want to be educated as music therapists and do not want to undertake ETMT training have other possibilities of education in Denmark. The answer is no. There is only one music therapy training available in Denmark, although they can be educated in other Scandinavian countries where the tradition is somewhat different concerning ETMT training.

Offering only one integrated music therapy programme has not emerged as a problem up to now and the benefit of it is that it has become a tradition and a culture of the profession of music therapy that music therapists have experienced and know about the psychodynamics of their personal issues, providing them with one of the useful basic tools for music therapy work with all client populations.

Nevertheless the training is surrounded and integrated within many other training disciplines (musical, theoretical, clinical). To underline the perspective of such an integrated programme I want to quote Mary Priestley's supervisor for eleven years, H.W.T.Redfearn:

> I think it is fair to say that the psychotherapist [what I call a music therapist] has to learn how to use feelings, the emotional reactions and even the instinctual impulses, aggressive, paternal, maternal, loving etc. which he finds himself experiencing in relation to the patient in the further understanding of his patient. In other words – he uses himself and his own

> emotional reactions to the patient as a kind of emotional and character-dividing sounding board. He has to learn to become more sensitive to and aware of what is going on inside himself in order to gain more knowledge of what is going on in and with his patient. (Priestley 1975, p.xi)

The potential space

In music therapy training, among other definitions, we use Winnicott's concept of 'the potential space' (or 'transitional area') (Winnicott 1971). In ETMT it is understood as the range of individual and inter-relational possibilities of action, which 'student-clients' are able to use, and are in contact with in playing situations during a developmental process. Developing process means grounding and extending the potential space of a human being in order to facilitate the fact that music therapists are:

> …basically determined by their artistic, fictional, artificial and playful character. Music therapy derives its strength from appearance. Even to the clients who enjoy a traditional and obviously preferential treatment with music therapists, that is, for those who are deprived of verbal language (in autism or dementia, etc.), music therapy does not offer in the first place an alternative language, but the possibility to obtain access, through fictionalizing, to their mental reality or to reality *überhaupt*. (Wigram, De Backer, Van Camp 1999, p.288)

For groups of 'student-clients' the playground of their potential space is:

- the group therapy sessions and the everyday milieu of the group of students to which they belong
- the processes going on with the ETMT teachers (the group music therapist and the individual music therapist) in exploring, grounding and expanding their 'potential space'
- their ability to go into therapeutic processes at the same time as training in many other musical and theoretical disciplines.

The ETMT teacher in a paradoxical way becomes both:

- a kind of partner to the student's disposition – a person the student may relate to in a very close way
- a part of a teachers' group in a programme where the student has to be evaluated and examined in many other disciplines – even if the ETMT teachers do not have other functions in the programme.

Once a year we have a 'check-up meeting' in the whole teachers' group where serious problems identified with students are addressed and discussed with the involved teachers and the student. We never discuss any personal information, but the ETMT teachers can communicate within a confidential frame to a permanent teacher (a professor in the programme) issues such as weak borders, extreme anxiety problems, low motivation or lack of ability of self-reflection, and so on. At the meeting it is then briefly discussed – if those particular issues are evident in the individual student both in experiential training disciplines and in other disciplines as well and whether the problem is being dealt with in a responsible way.

The students know that we have these meetings, and that we never bring up issues that have not been discussed with the student beforehand. If there is general anxiety about a student, the student will be immediately informed and advised what to do.

The basic tools

In the self-experience disciplines the students as student clients are trained in the following areas:

1. learning to be familiar with their personal improvisational language – especially in the music;
2. experiencing the power of music as a tool for reflection of mental abilities, limitations, and preparedness;
3. learning to be part of ongoing dynamic processes over time;
4. learning to deal with projections, introjections, and self-containment in practice;
5. learning to develop and keep a high level of sensitivity and flexibility in music therapy practice;
6. learning how to be vitally involved, and at the same time to survive as a music therapist.

Concerning the last area, two issues are important. The students must learn to protect themselves and build up their own energy in, and between, music therapy sessions. The students also have to learn to have their own needs properly fulfilled so the clients won't be placed in a situation where *they* must fulfil the needs of the *therapist*.

The musical framework around ETMT

During the music therapy programme music is taught and experienced in many different ways – as formalised knowledge, as skills, as a symbolic product, and in different improvisation models. The improvisational models which are closest to the musical learning processes in ETMT can be divided into four areas:

1. improvisation within identified musical styles;
2. improvisation based on musical clinical guidelines not necessarily representing a recognisable musical style;
3. improvisation based on associations (images, memories, and so on) symbolically expressed through music;
4. improvisation expressing inter-relational experiences and identity in music – 'here and now relationships' or 'as if relationships'.

Area One belongs to the disciplines of training musical skills whereas areas Two and Four mostly belong to the disciplines of training therapeutic skills. Area Three overlaps between disciplines.

Structures of the ETMT as a compulsory part of the programme

This part develops a progression from the students being in the 'client role', to the students alternating between being in the 'client role' and 'therapist role' in a methodological training where the students are the subjects for the learning processes of one another.

During the first two years in the programme the students are in the client role in group music therapy for the first year, and individual music therapy for the second year. Group music therapy is interrupted by a four-week observational practicum in the second half of the first year.

In the first half of the second year individual music therapy is undertaken. In the second half of this year students go in pairs to observe each other in individual music therapy to have a chance to learn from another individual process, and to follow the approach of another ETMT teacher. The students are obliged to fill out forms for each observation and deliver their observation notes to the ETMT teacher. After the therapy has ended they have time for discussion with the ETMT teacher.

In the third year of training the students undertake group therapy where they are 'role playing' different client populations prescribed by the teacher,

and alternate between being a client, and being the therapist(s) under direct supervision. This is a process to explore their resources to develop group music therapy skills with a variety of clients. This training is combined with a one-day-a-week practicum at an institution outside the university under supervision from music therapists employed by the university

In the fourth year of training the students undertake:

- psychodynamic group leading – where the students work with each other. They are there as 'authentic student clients' and as therapists. They are all required to take turns in being responsible as the group therapist under direct supervision. This is a process exploring their resources to develop group music therapy skills to work in depth with psychodynamic processes. This process is for the first half of the fourth year;
- intertherapy – where the students work with each other individually, taking turns in being the client and the therapist under direct supervision. This is a process exploring their resources to develop individual music therapy skills to work in depth with psychodynamic processes with the same student client over a longer period of time. This process is for the second half of the fourth year;
- Guided Imagery and Music level I – a one-week block course where the students make exercises in dyads: 'Guide and traveller' and group exercises based on GIM method as student clients. This is a process where the students can experience very powerful music listening in a deeply altered state of consciousness and explore their resources and interest in continuing the GIM training to levels II and III after finishing the MA training.

This training is combined with a one-day-a-week practicum at a different institution outside university under supervision from the university.

In the fifth and last year of training the students are in practicum for half a year at a third institution outside the university before finally writing their master's thesis during the last half year of training.

The ETMT teachers receive regular supervision by a psychologist not involved in the programme. This supervision allows space for the ETMT teachers to share problems and issues that evolve during the process work with someone not included in the programme as a teacher. At the same time their

presence in the programme and at the teachers' meeting creates security that those students with serious problems will receive the necessary attention and advice.

Ethical rules around the experiential training disciplines

As mentioned above, clear ethical rules and a respectful understanding of the processes involved in the training are necessary.

The most important ethical rules are:

- Work takes place behind a closed door and no disturbances are allowed. There is a 'Don't disturb' note on the door, which is highly respected by everyone.
- All ETMT teachers are subject to professional confidentiality according to the ethical code for professional music therapists. That means no personal information can be made public. At the same time ETMT teachers, in their role as employers of the university, are obliged to report specific difficulties which may be identified as problematical for students' further development as professional therapists. That means that other problems than those concerning the client (for example, being dangerous to her- or himself or others – which is the general rule in the ethical codes) can be reported within the programme due to the specific aims of the ETMT process.
- All sessions are recorded or videotaped for several reasons. The students have a responsibility to reflect on their own process as an added learning process to the therapeutic process they experience. In case of disagreements regarding 'serious problems' between the student client and the ETMT teacher, a neutral third party (supervisor) can listen to the tapes to try to double check the evaluation of the ETMT teacher.
- Supervision is compulsory for the ETMT teachers.

Taking part in ETMT differs from a purely personal, individual music therapy process. Some special circumstances have to be taken into account:

- The student client cannot just choose her or his therapist – he or she can express wishes about the sex of the therapist and this wish

will be accepted if in any way possible. There are, at the most, three therapists available, two female and one male therapist.

- There is a prescribed number of sessions available – no matter where you have come to by the end of ETMT. (If the student wants, or needs, to go deeper into her or his personal process he or she must consider obtaining personal, individual therapy outside the training programme.)
- The development of the therapeutic process will be subject to current evaluation concerning future professional work.

Learning processes and ways of understanding steps of progression in ETMT

In the first two years of training, where the student is in the client role, there is no formal evaluation except for the responsibility of the therapist to be aware of the potential for serious problems for future professional work.

For the ETMT teachers to be able to orient themselves in the direction of this therapeutic process, we have developed the following working scheme of learning processes which has evolved through the years to be representational for a wide range of personal 'stories' that emerge in the music therapy:

1. learning to see/experience intimate relations/parents in the way they are and the way you want them to be (distinguishing ideal from reality);
2. learning to contain and accept pain, disappointment, aggression, joy and other feelings related to intimate relationships.

In these two steps of the learning process conscious awareness of projections and transferences are addressed musically and verbally:

3. learning to recognise oneself in 'one's own eyes' instead of in the eyes of other people;
4. learning to act the way you feel is right for you – independently of parental censorship and of your own defence mechanisms, in a responsible way for yourself and others.

In these two steps of the learning process conscious awareness of introjections are addressed musically and verbally:

5. learning how to develop important tools for clinical music therapy work when you contain feelings at the same time as you allow feelings to appear and to be used as information in the relationship and interaction.

In this last step of the learning process self containment as a music therapy tool is addressed.

This way of understanding therapeutic learning process is only one way of understanding, and it is related to a psychoanalytical/psychodynamic way of understanding human beings.

Another orientation tool for understanding ETMT work with music therapy students mirrors developmental work with boundaries in the 'here and now' expression of and relationship to musical group work. Steps of development here are recognised through the student's ability to fill out and identify her- or himself as being in three different communication spaces:

- a private soundspace – a space inside oneself and just around oneself;
- a social soundspace – a space for interaction where one can be influenced and can influence others;
- a soloist soundspace – a space for taking over a full authority, for example imagining being on the stage as a soloist without taking the presence of the others into consideration.

This exercise is carried out in a group with the students in pairs where one is improvising and the other is carefully listening to the partner to give verbal feedback afterwards. An important element for this method of understanding steps of development is to be aware of 'if' and 'how' the student is able to keep in contact with the private soundspace when being in, and operating within, other soundspaces.

Paradoxes

In order to avoid 'trust problems' the ETMT teachers have to be conscious of, and able to deal with, paradoxes such as:

1. Remember/forget

The ETMT teacher is the one who is supposed to remember the important information the student brings into the process work, and the one who in a later

part of the therapeutic process can refer to former information (verbal or musical) which might be important for the 'here and now' issue being addressed. On the other hand the ETMT teacher has to enter each individual therapy session with students knowing exactly nothing – thus letting the student be present and have a chance to 'be born' in each new moment.

2. A disciplined way of being present (disciplined subjectivity)/ being rather authentic

The ETMT teacher has to be able to deal consciously with transference and countertransference. This means that, for example, the ETMT teacher must often accept playing a specific role for the student-client to be able to clear up the meaning of the role he or she is put into, and to give the student a chance to confront a negative or positive transference. In these situations the work of the ETMT teacher can be compared with that of an actress on the stage – the role must be so convincingly played that it moves the audience. But at the same time the ETMT teacher must be as authentic as possible in her or his way of being present in the different situations in order to keep the basic trust of the student-client alive.

3. Knowledge/no knowledge

In a programme where ETMT is a compulsory and integrated part of the programme you cannot avoid mixing roles as an ETMT teacher. On the Study Board of the programme we have to decide whether it is possible for an ETMT teacher to be an ordinary teacher or examiner for the student before being an individual therapist. We have also to decide whether it is possible to be an ordinary teacher or examiner for a student after the therapy has ended. Mixed roles are not possible, especially simultaneously. As it is now, we do allow the ETMT teacher to teach preparation for practice both before and after the individual therapy, but he or she is not allowed to be in a role involving day-to-day teaching or any formal evaluation or examination procedures simultaneously with undertaking ETMT work.

Whenever an ETMT teacher becomes an ordinary teacher after the therapy process has ended he or she has the responsibility of 'forgetting' all confidential information from the therapy sessions and of meeting the student in this new role-constellation. We also emphasize the importance of the responsibility of the student as observer in the individual therapy to maintain confidentiality when observing a student colleague during the last part of the individual ETMT.

4. Love/not make love

Last but not least – it will be emphasized by the employers of an ETMT teacher the importance of being able to love the students as human beings (primary love). It can only be formally tested by ensuring he or she as a music therapist has undertaken a relevant experiential training, and also through information and interview when employed. At the same time he or she is informed of the fact that he or she is not allowed or supposed to have personal sexual relationships with any of the student clients.

As an ETMT teacher you cannot help often being the target of many strong positive – or in some periods – negative transferences, and the student may 'fall in love' with you. This can be a very important part of the developmental process if you as an ETMT teacher can contain and handle this in a respectful way. As mentioned above we have one male and two female ETMT teachers so that those specific wishes from the students about the gender of the therapist can be met when possible.

A brief description of the aim and structure of the different disciplines in the ETMT track of the programme

To give a short survey on the progression of self-experience disciplines at the MA programme in music therapy at Aalborg University, I will now briefly present the different disciplines focusing on aims, process issues, and evaluation.

4. Psychodynamic movement

This discipline occurs in five blocks of six hours during the programme and is placed at the beginning and end of the first semester, the end of the second semester, the beginning of the fifth semester, and at the end of the sixth semester. The discipline contains very basic elements for therapeutic work with a focus on the body sensation, and body and voice awareness and experiences. The work is based on the 'here and now', and not focused on biographical material of the students as is the case in the ETMT work in group and individual therapy.

It can be seen both as a preparation for therapy work, a place to test out the developmental processes of therapy work, and a place for finding inspiration and ideas for psychodynamic group leading work undertaken later. The students are in their student-client roles.

The aims of the course are as follows:

- to give time for deep experiences in relaxation, sensation and levels of expression and contact as a preparation for being a student-client;
- to give the students a chance to test their own self-development during self-reported experiences in repeated body and voice exercises, such as the exercise of the soundspace of three communication levels.

The written report the students make in the first semester on their experience of the soundspace levels is put away and opened again at the end of the sixth semester when the students have undertaken group and individual ETMT, and the discipline of clinical group leading skills.

There is no formal evaluation of psychodynamic movement. The course is taught by the contact person for the ETMT track of the programme and thus gives this contact person a feeling of each student and her or his development during the training within self-experience and self-development. (Pedersen 1993)

Group music therapy

Group music therapy takes place two hours a week for one year in groups where the maximum class size is six students. The aim of ETMT in groups is to create a setting where the students can express and reflect musically their private, social and performance-like levels of awareness and communication.

The setting also encourages the students to establish an open, trusting and tolerant atmosphere.

In order to give the students the possibility experiencing how to be with and express a variety of needs and emotions, the ETMT teacher prepares a certain structure and playing rules for each session based on experiences from the previous session.

Musical and verbal parts will alternate and all verbal reflection will be related to the music, the individual in the 'here and now', and the individual being a part of a group dynamic. Biographical issues will only be taken into the process as far as they develop from, or can be related to, a 'here and now group dynamic process'.

There is no formal evaluation of group ETMT. The ETMT teacher refers to the contact professor only if serious problems emerge (see above).

Individual music therapy

The individual ETMT is the discipline where each student can work in depth with authentic personal dynamic patterns, and thus focus on limitations and resources concerning their future identity as a music therapist. The main aim of the work is to ensure that the future music therapist does not unconsciously shut out needed developmental processes of future clients because of her or his own blind spots.

In the first session the student-client and the ETMT teacher pin down a topic as a label for the whole year. In each session the work can move in many different directions but it will always be related to the overall label during the process.

Methodologically, one can say that the dual work between the ETMT teacher and the student-client moves between three levels of interaction and communication. These movements are not always linear but can be outlined in circles, jumps, spirals, and so on. The three levels of interaction can briefly be defined as:

1. *self healing* through work with voice and instruments to extend the awareness of sensing, of recognising boundaries, of being centred and grounded, and of focusing one's ability for empathy;
2. *self holding and integration* in the musical improvisation – to stay with, to stand, to contain and to focus, and express physical/mental energy and emotions; to better integrate rational/emotional parts of the person, or better integrate body and mind;
3. *self-expression and communication* through musical improvisation to explore potential for creativity and interaction abilities, and to train flexibility relating to levels of contact and communication.

Examples of overall label issues can be:

- developing identity in general and as a music therapist;
- identifying and balancing male and female parts;
- lack of self-consciousness and anxiety of being rejected;
- to be more confident in accepting and expressing feelings – fear of showing anger and rage, lack of courage to show loving feelings towards others.

As a result of this overall issue for the therapy most students come to work with their relationship with their parents or other intimate relationships in order to be able to contain feelings such as pain, sorrow, betrayal, joy, and so on. This helps the student to be familiar with containing and expressing those feelings musically and verbally.

Even if many of the ETMT processes address painful feelings and issues, the purpose and result is a wider range of personal resources and an enlarging of the students' ability to resonate with other people without losing self-identity and consciousness.

The evaluation procedure follows the one for group ETMT as described above.

Clinical group music therapy skills

The training in clinical group music therapy skills gives each student the chance to be a therapist in group work, first in a pair and then individually. They prepare and carry out therapy sessions where the other students role play clients with a range of pathological problems from the general areas of learning disability, psychiatry, social services and special education. The students who are role playing clients are given short descriptions of the history and problems of the patient/client they will play, and are then brought into the therapy room for a group therapy session. The student therapists are given supervision some days before the session to address their understanding of the needs of their clients, the function and process of the session they are planning, and their therapeutic role. The session is carried out in a safe space, with careful attention to boundaries, in order to create as real a situation as possible. After the session, there is a lengthy feedback, with commentary from the 'clients', therapists and observers. Analysis of the process of the session is undertaken, reviewing the video made of the session, and alternative possibilities for events that occurred during the session, both musical and verbal, are discussed.

A psychodynamic approach is used both in the sessions and during the analysis to explore the students' experience as clients and therapists. Attention is given to the following issues in the work:

- the development of the therapist's musical identity;
- the development of the therapist's therapeutic identity and presence;
- the development of the therapist's skills;

- understanding the needs of the clients from different clinical populations;
- developing method and technique in group work;
- exploring and coping with a dynamic process in group therapy;
- storing and recalling events in the sessions during feedback;
- awareness of, and supervision on, transference and countertransference in the session;
- experiencing the role of a client and exploring the impact of therapy as a client;
- intuition, insight and interpretation in the therapy process.

The sessions are supervised, observed and contained by a qualified teacher/therapist.

This training takes place over the whole of the third year of the programme, and is examined by an external examiner who observes a live, 'here and now' experience of the group therapy with role playing. The students are examined on their ability to work within group therapy process, understand the needs of the client, their role as a therapist, and how to feedback through an analysis of what happened in their session.' (Wigram 1995, pp.199–212)

Psychodynamic group leading

Psychodynamic group leading gives each student a chance to be a group leader twice, first for half an hour, later for one and a half hours under direct supervision. Subsequently there is a lengthy feedback from the group members and the supervisor.

In psychodynamic group leading the students take turns in being a solo group leader for a group of students who are there authentically as student/clients. The aim of the group leading is to train the students in work with counselling with normal to neurotic clients in group dynamic forms both on a pre-structured and on a *prima vista* base, musically and verbally. Timing, states of consciousness, voice qualities, therapeutic presence, musical facilitating, and verbal clarifications and interpretations are in focus. The group leading can be seen as the students trying out alternately being the therapist and the client, the form of ETMT in groups which they experienced from a client's perspective in the first year of training.

Authentic group dynamic problems and resources are in focus and they are a guideline for the therapists' preparation of the session. The student-therapist undertakes pre-supervision before the session. The sessions are supervised, observed and contained by a qualified teacher/therapist.

In psychodynamic group leading the internal examination involves the student being a group leader for half an hour for a group of other music therapy students other than those from her or his own peer group, who are student/clients in the training discipline. The thirty minutes have to be structured into:

- creating a frame for the group members to become present and ready in the room and for the session;
- giving clear instructions for dynamic work and clear playing rules;
- taking part in or carefully listening to the musical improvisation and reflecting on the therapist's role;
- facilitating/clearing up and interpreting during the verbal part and reflecting on the therapist's role;
- closing the session in a responsible way.

After the clinical presentation, which is observed by the supervisor or internal censor through a video link, the student/therapist reflects on her or his group leading in discussion with the examiners, including further suggestions for the work. Finally the student obtains a professional and personal feedback from the internal censor who has not been the ongoing supervisor. (Pedersen in Bonde, Pedersen and Wigram 1999)

Intertherapy

In Intertherapy training the students get a chance (the only one) to work individually as a student/therapist with another student/client – the same student – in an *ongoing psychodynamic process under direct supervision* with counselling work.

An Intertherapy session lasts for two hours a week over six months. Each session includes two students taking turns in being a student/therapist for each other for two forty-minute blocks, under direct supervision, and subsequently twenty minutes of individual supervision for both students. Intertherapy can be seen as the students' chance to revive their individual ETMT training from the second year of the programme, but in this situation taking turns in being the client and the therapist.

The aim of Intertherapy is to train and develop the students' ability to follow, to recognize and to change patterns in a dynamic process in the dual work between the student/therapist and the student/client. Also, the quick shift of being in the different roles is very important for future work where you might have to be ready for therapy work even if you have just experienced deeply emotional situations yourself. In this training the students in the therapist role practise the three levels of awareness and communication described under the individual ETMT discipline.

In the Intertherapy examination each student prepares a case illustrated by video examples from the therapy process showing and reflecting the progression of intertherapy in phases from the following perspectives:

- the student/clients' development (changes of patterns);
- their role as student/therapists in the different phases;
- their understanding of their own development as therapists and their self-experiences in the different phases.
- (Pedersen and Scheiby 1999)

Guided Imagery and Music, level I

'From 1999 level I of the GIM training has been included in the curriculum. The Bonny Method has been chosen as the most suitable receptive music therapy model in the context of the Aalborg music therapy training programme.

The course follows the guidelines of the Association of Music and Imagery and is approved by AMI. There are 8–12 students per class, and the course is led by an AMI-endorsed trainer and assistant. The module comprises 35 hours of theoretical, practical and experiential instructions. The training is arranged either as a combination of one-day seminars and one intensive workshop, or as a five-day intensive workshop.

The theoretical elements are: history and philosophy of the Bonny Method of Guided Imagery and Music, and current theory and core concepts including the psychological nature of imagery, applications and contraindications, image potentials of music and music programmes, music theory and analytic concepts relevant for GIM, states of consciousness, basic induction skills, ethics and standards of practice.

Practical and experiential elements are:

- exercises in dyads: 'Guide and traveller';
- group exercises based on GIM methods;
- demonstration session by primary trainer;
- creative drawing/writing based on imagery and music experiences.

> The GIM course is placed in the eighth semester (all students have passed the BA level), when the participants are psychologically and experientially prepared for the often very powerful experiences of music listening in a deeply altered state. An introductory GIM course has already been given in the first semester, and GIM topics can also be integrated in other training disciplines. Each student is evaluated, with the student's participation in the training, potential as a GIM facilitator, and readiness to proceed to Intermediate level II training being assessed. (Bonde in Bonde, Pedersen and Wigram 1999)

Conclusion

It is not always easy to run such an integrated programme. At the beginning we had to argue again and again with the university board about the relevance and also the ethical rules of this track in the programme.

During the first seven years (from 1982 to 1989) ETMT was carried out on an experimental basis and we never knew if we were going to be allowed to continue each year. In 1989 the programme was subject to an evaluation from the Ministry of Education (questioning the students, the teachers, the working places of the first candidates, and so on) about the relevance and ethics of the ETMT as a compulsory part of the programme. The result was positive and we have had no further critical questions from the university.

In 1998 I made a survey, together with Scheiby, concerning the candidates' ability to use their Intertherapy experience in their contemporary work. Ninety per cent of the questionnaires were positive.

We have always warned the students at the entrance test about entering such a complex programme. Today, not only students from Denmark but also from other Nordic countries want to join the programme because of the integration of this specialisation into the programme.

We have had very few problems of students disagreeing with the ETMT teachers' evaluation and we have been very careful in trying to solve these problems.

During the course of the ETMT, some students who previously had either declared or undeclared personal problems went into a critical state and needed to be referred to the healthcare system. In some ways this process has revealed inherent difficulties and problems that needed attention, and certainly needed addressing before the students attempted to continue training in the complex field of music therapy. However careful one tries to be at the entrance evaluation, and subsequently in the professional and scientific training, one can never be totally secure about what future personal problems may emerge during therapy work. I personally feel sorry for the few students who have had to come to terms with the fact that they could not continue their music therapy education for personal reasons. On the other hand students who go into a crisis, although not defined as pathological, during the training, may have a very good possibility of developing basic mental tools to understand and musically resonate with future clients.

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CHAPTER 12

Psychodynamic Movement

A Basic Training Methodology for Music Therapists

Inge Nygaard Pedersen

Introduction

Psychodynamic movement is a term originally created by Mary Priestley, covering a part of her clinical work with long-term psychotic/schizophrenic inpatients at St Bernhard's Hospital, London, during the seventies and eighties.

She introduced the model for the student group of the Herdecke music therapy pilot programme (1978–80) in Germany, where I was a student. In her presentation she introduced the model as the result of her work with the clients mentioned above, but she had also found it very important for music therapy students to experience when in the client role. Her idea of letting us (as students) experience the model in the client role was similar to the one described in her book *Analytical Music Therapy* in essay twenty-nine on *Intertherapy*:

> During this part the trainee learns something about what a therapist is and does and tries to avoid doing. He begins to explore his own inner life with the aid of shared music and words and, hopefully, he will put some trust in the work that he and his therapist do together. He will probably begin to understand something of the power of improvised music *to express his own feelings* in contrast to playing those of a composer. He will surely also have *some experiences* which will enable him to empathize more closely with his clients as they trace *some of their emotional roots back into their earliest years.* (Priestley 1995 p.297)

One of my fellow students at Herdecke, Benedikte B. Scheiby, and I found this part of the training very inspiring and we decided to extend and develop the model of psychodynamic movement into an ongoing training model for music

therapy students. At the beginning we were allowed to experiment with this idea with our fellow students at Herdecke.

We started this work mostly because we both thought that such disciplines were missing in the daily training at Herdecke, where bodywork, movement, dance, voice, and instrumental improvisations were combined and explored within a therapeutic setting.

The core of psychodynamic movement is improvised movement by one or more persons on an agreed topic, accompanied by one or more persons who follow and interpret the movements in a parallel instrumental/voice improvisation. This is also called *improvised movement to improvised music*.

This model or discipline within a training programme has developed through three generations of music therapists. As mentioned above, the term originates from Mary Priestley and was originally coined within her work with inpatients. We (Scheiby and I) developed this model into a continuous discipline for music therapy students, and, later on, I revised the discipline together with a member of the first student group from the postgraduate music therapy course in Hamburg, Susanne Metzner. Lately all three of us have developed the discipline to a point where it is possible to teach it as a single teacher (trained music therapist) and not – as originally – in a music therapist dyad.

Before I go into more details about my own work with the model during the last few years, I would like to give a survey of the most important threads in the development of the discipline of psychodynamic movement through three generations.

The model as developed by Mary Priestley

Psychodynamic movement was, in its original form, composed of the following elements listed below. In this form there were always two music therapists – a principal therapist (group leader) and a co-therapist – present in the room:

1. All group members are sitting in a circle in chairs. The group leader addresses the whole body mentioning all major body parts (arms, shoulders, stomach, legs, face, and so on) in a 'tighten and relax' repetition of verbal phrasing.

The idea of this part of the model is to make the group members pay attention to different body parts and to different experiences of tension and relaxation.

2. After this exercise the group leader selects two different pieces of music for free dance. It can be music with, for example, a polarity of moods or a polarity of tempi. The only instruction is that you are allowed to move freely to the music, listening to and following the body signals arising from listening to the music.

The idea of this part of the model is to make the group members establish an inward contact with their bodies and to let body sensations evoked by the music be a basis for associations and feelings.

After these two free dance experiences the group members sit down in chairs again and there is a verbal round when every participant expresses her or his experiences.

3. Out of the verbal round the group leader creates a common topic (a playing rule) for the psychodynamic movement part, where a co-therapist accompanies the movements of the group members on a grand piano.

Examples of topics may be:

- walking in the forest – coming to a glade;
- splitting the room in two parts – in one part I allow myself to be an introvert, in another part I allow myself to be an extrovert;
- expressing anxiety;
- being aware of the distance and closeness I choose for myself when relating to the other members of the group during the psychodynamic movement.

The idea of this section is to give the group members a chance to explore aspects of their personality (feelings, communication patterns, contact patterns, and so on) with the body as a basic tool of inner experiences and with the music simultaneously provoking and containing, and maybe reinforcing, the experiences. Simultaneously you are not alone (you may use some of the others to explore yourself), or you may stand by yourself and know that the others are dealing with the same task. You may be inspired by movements of other participants or you may use the group to isolate yourself (very visibly) from the others.

After the psychodynamic movement section there is a verbal round where the participants have the chance and space to talk about the psychodynamic movement experience. The participant/patient chooses what to verbalize, whatever is important for her or him. The primary task of the group leader is

listening and accepting. The group leader may also ask exploratory questions such as:

- 'I noticed you stayed all the time on the same spot – which kind of experience was that for you?'
- 'You seemed to express a lot of feelings – was this the way you felt it yourself?'
- 'Could you put some words to the feelings?'

The questions are more exploratory than interpretative, and the expression of the patient will be listened to as being authentic of this specific patient at this specific moment.

The idea of the verbal round section is to make the experience of the body sensation and expression (combined with music listening) more conscious and clear for the patient. Most psychotic patients have very little or almost no contact with their body sensations – their fantasies seem to be cut off from body and feelings. Therefore psychodynamic movement can be a way to better integrate a more comprehensive self-experience for those patients. The idea of improvisation (in this context defined as non-determined movement patterns where you do not have to learn or to follow other people's movements) give the patients freedom to stay with their inner movements or to express inner movements through outer movements in their own tempo.

4. At the end of a one-and-a-half-hour session of psychodynamic movement the group members are told to lie down on the floor on a mat with their eyes closed. The group leader makes a quick check of the body parts in terms of 'be aware of a certain part of your body and allow yourself to relax this body part'.

After this 'check of the body parts' the co-therapist plays a small improvised piece of relaxation music on the grand piano while the participants are lying down with closed eyes. The idea of this final section is to try to give the participant/patient a chance to be more aware of the body in a relaxed state and to be able to contain and also let go of the problems confronted in the session.

In this way the training gives you both the possibility to learn to trust your body in working with traumatic problems, and also to learn to trust your body in letting the traumatic problems go off.

If you want to use this method with psychotic patients you have to be aware that many of them are not able to lie down with their eyes closed (this must be presented as an option) and many of them are not able to lie down for more

than a few minutes. Lying down may be experienced as being in prison – not being able to get out because of the half-suggestive voice induction and the relaxation music. On the other hand this is also a chance for those patients to fight and challenge their impulses to run away from any unpleasant situation, knowing that whatever you do it will be accepted as your best choice.

Mary Priestley did her clinical work in a porter's lodge with a grand piano for years, but the clients turned up every time anyway and seemed to be very enthusiastic about their work, especially about the idea of moving to the music and at the same time working through some problems. For years the co-therapist at the grand piano was her colleague, the pianist and music therapist Marjorie Wardle. Being there for a two-month practice I found it incredible to follow the process going on with these deeply psychotic clients.

The model as developed by Pedersen and Scheiby

Scheiby and I tried to turn the model into a suitable continuous basic training discipline for music therapy students. We thought about the improvisational parts of psychodynamic movement in the same way as we thought about the training in voice and instrumental improvisation within the programme. Being able to improvise with any kind of tool as a therapist means knowing the tool very well. Technically, as well as musically, you must know all kinds of expression possibilities if you want to be able to express yourself within improvised forms and patterns. We tried to integrate body training, body awareness and body communication as forerunners for the psychodynamic movement part of the model in order to prepare the bodies of the participants to become an improvisational tool.

We also developed exercises in improvising movement and music in a pair. We kept the idea of being a therapist couple in the working situation, but we often reversed the roles of being principal therapist and co-therapist within a setting. We always agreed on the roles beforehand, though.

We worked on new team ideas, for example, in a team consisting of a principal therapist and a co-therapist; the co-therapist joins the student group (or patient group) in the psychodynamic movement part and thus stays in direct contact with the energy and communication level of the group movement improvisation. Within this framework the principal therapist stays out, in order to be prepared to contain and keep an overview of the entire improvisation. One or more students (if in student groups) will be chosen to play the musical part of the psychodynamic movement.

It should be noted that this idea was already introduced by Mary Priestley at Herdecke when she tried out the original model with the Herdecke student group. She never brought her co-therapist and so she chose a student in our group to be the musician for the psychodynamic movement part. This is also an extraordinary feedback source for the students improvising the music – they can have comments from the music therapist and/or from the other students who were moving to their improvised music. With patient groups this model is not realistic, because the patients mostly do not want to take over the responsibility of playing the music. So either the original idea has to be followed, or the music therapist has to play the music and keep the overview at the same time. This is very hard work indeed.

Improvisation exercises as forerunners for psychodynamic movement

As Scheiby and I extended the model into a continuous basic training methodology we also added exercises as preparation for this double improvisation work (improvised music to improvised movement), for example letting:

- a student play an instrument for another student dancing (improvised) with or without a given topic;
- two students play instruments for two students dancing together – each musician following one of the dancers, again with or without a given topic;
- three students play instruments for two students dancing together, with or without a given topic. Two students follow one dancer each, while the third musician expresses what goes on between the two dancers, and so on.

These exercises can be varied and elaborated.

In the feedback of the double improvisations the following questions were addressed:

- How did the dancer feel accompanied by the musician in general?
- How did the dancer accompanied by the musician feel concerning tempo, intensity, sound, dynamic, and so on?
- Who was the leader/follower, or who took turns?
- How did the dancer and the musician feel inspired by one another?
- How did the dancer/musician relate to a given topic?

Body training/body awareness as forerunners of psychodynamic movement

Another aspect of giving the discipline the status of a continuous training methodology for music therapy students was that we developed a general form for each training block (course), assuring that the students would experience a variety of training elements in order to 'tune their bodies' to be used as instruments in clinical psychodynamic movement work. We both believe that the body tuned as an instrument is a very important tool in all kinds of music therapy practice – especially in work with clients who cannot verbalize. The body and movement work was especially emphasized here as the students undertook voice and instrumental improvisation training in other disciplines in the programme. (In the Aalborg MA course the students have solo lessons in voice techniques and voice improvisation for three years, and piano technique, piano improvisation and clinical improvisation for four years. They also have parallel courses in body and voice techniques and improvisational techniques, emphasizing the technical training and ability of expression and communication not focusing on the self-experience process.)

The general form of psychodynamic movement had the following progression or framework:

1. awakening;
2. warming up;
3. energy work;
4. body analysis;
5. psychodynamic movement;
6. relaxation/massage.

A complete round normally lasted one day (minimum), although the form could be filled up in a very flexible way.

In a one-day seminar we mostly went through the framework literally. Within a two-day seminar we might have a long warming up on the first day, without analysis, and a short warming up on the second day, with more emphasis on the analysis, and so on.

We found it very important that there should be a long preparation for the psychodynamic movement section, and that sufficient time should be left for the verbal round and the relaxation/massage work afterwards.

Assessed as a whole, important issues in each part of the form could be described as follows:

1. *Awakening*

   We often start up with individual work in a group setting where each student is lying down on a mattress with closed eyes. The principal therapist guides a relaxation exercise, verbally addressing different body parts with some kind of continuous focus (focus on inner space, or feeling relaxed in the different parts of the body, and so on) and mostly ending up focusing the awareness on a symbol (like a ball of light), or finding a 'here and now centre-point' in the body and expressing this centre-point through, for example, voice and sound. This type of guiding may also lead a relaxed student into a fantasy journey.

   The co-therapist may play relaxation music to the last part of the exercise (awareness of a symbol or a fantasy journey).

I have undertaken three years' full-time training as a relaxation and massage teacher, and Scheiby has taken several courses within the field.

The idea of beginning with relaxation exercises is to let the students gradually get in contact with their bodies – with their inner body life and with their fantasy life, as it can be explored from a base of body sensations. The idea is also to give the students a chance to focus their mind and body for the coming work of the day.

2. *Warming up*

   In the warming-up phase we introduce free dance to different music styles – often ethnic music like African drums or Japanese Kodo drums, or modern ballet music.

   The instructions are like the following: 'Move freely and allow yourself to listen to what your body might like to do with the music', or 'Try to let your head go and let your body guide you through the dance to the music'. We might use a more specific instruction, saying: 'Imagine yourself standing inside a huge football, where you can only reach the inner walls of the ball when stretching out totally. During the dance stay at the same spot on the floor and paint all the inner walls of the football. Notice that when you paint on one spot on the inner wall your whole body will follow the painting movement.'

The idea of warming-up exercises is, apart from warming up the body, to give the student a feeling of the body as a whole when dancing – for example, when

I move my arm or leg this way or in this direction it will influence my whole body movement – in order to give the students a chance to explore their bodies as a holistic tool, where you can model, form and explore positions, space, tempo, sensations, weight, in different combinations and in a free-floating way.

3. *Energy work*

   In the body energy work we use basic traditions of Alexander Lowen's bioenergetic body exercises (Lowen 1977). We have experienced that basic elements in music, such as, for example, basic repeated rhythms, can have a similar effect as some of the basic bioenergy exercises. The exercises of Lowen's bioenergy are still very useful when training awareness and knowledge of different deep parts of the body. Examples could be *The Bow*, where you get deeply into the long muscles along your spinal chord; or the exercises of hands, arms and shoulders where you get into hidden tensions of deeply rooted muscles around the shoulder joint area, the chest and the area around the heart. Sometimes we have tried to combine the traditional exercises with music or musical ideas, such as, for example, instead of standing in the basic bioenergy position with lightly bent knees until the legs start shaking, you may stamp around on the floor with heavy steps to some slow drum music, possibly combined with voice sounds based on the stamping movements up to the point where your legs start shaking.

   The basic idea of bioenergy is to confront the tensions hidden in the body in such a way that you release pains and feelings. Through this release caused by bodywork you get in better contact with your body energy and gain a better sensation and feeling of yourself. In order to get a better understanding of what might come up in energy work and in psychodynamic movement work in general we used Alexander Lowen's *Map of Emotional Territory* (see Lowen 1965). Mary Priestley also refers to this map as one way to understand the emotional spectrum (Priestley 1994, essay three).

Scheiby has undertaken a postgraduate training in bioenergy and I myself have undertaken several courses in this kind of work. In psychodynamic movement work this section of the training is a very powerful tool to open up the body – to make it more sensitive, to receive body signals (feelings) from within your

own body and from the bodies of others and also to get in contact with very deep (often primitive) feelings, such as rage or powerlessness, and so on.

4. *Body analysis*

   The basic literature here is Alexander Lowen (1975a) and Ken Dychtwald (1977). This part has two focus points. The first focus point is to train the students to be very empathic to other people's ways of standing, walking, carrying their bodies, and so on. The students are told to work in dyads where they take turns: Student A is standing, moving, walking, and so on, while student B watches and imitates the body and movements of A. B must try to be aware of the experience of this imitation, and give feedback to A.

   The second focus is learning more about the body by looking in the mirror or getting feedback from others watching your body with its balances and imbalances in, for example, upper part/lower part, or left side/right side of the body. The work takes place in dyads, and the students are told to read and analyse each other's bodies to become knowledgeable in general; knowledgeable about stronger or weaker parts of the body and about specific problems connected to these findings, for example to explore what might be problematic life patterns for you if you often have pains in your knees or in your back, and so on.

The goal of this analysis is not to create persons without weaker parts of the body, or to give information about good or bad body constitution. It is meant to increase knowledge about the information any body can give concerning the person's life situation and the person's strong and weak points. Everyone can obtain more openness to body awareness, can learn to accept oneself and one's body the way it is, and might even learn to take better care of the body.

5. *Psychodynamic movement*

   This part of the work is very similar to the original idea in Mary Priestley's model. The group leaders choose a topic for improvised movement to improvised music, and, as mentioned above, we often let one therapist join either the movement improvisation or the music improvisation especially when working with student groups.

   We have tried out several models, for example:

- the principal therapist is observing, the co-therapist is improvising the music (solo);
- the principal therapist is observing, the co-therapist is moving within the group, with one or more students improvising the music;
- the principal therapist is observing, the co-therapist is improvising the music together with one or more students;
- the principal therapist is observing, the co-therapist is observing.

During the years we noticed that the first model was most useful in the initial phase when working with a student group, and the last three models became gradually more convenient as the process developed within a student group.

This part of the psychodynamic movement work as a whole creates a space for the students, where they can go deeply into psychic problems and resources and gain insights at a very deep level. Students often get in contact with very strong feelings of being let down as children – they may feel and express sorrow, loneliness, joy or rage, and they have a chance to go with the feelings and give them powerful expressions. These strong feelings and expressions may be accepted, even met and contained by the other participants.

The verbal round after psychodynamic movement is very important – and it is important to give enough time for the students to stay in their final position of the psychodynamic movement and reflect on their experiences before they begin to verbalize on them. Here again the principal therapist is the one who stays in contact with everyone during the verbal round and who gives a lot of empathy and asks explorative questions. Only if the co-therapist has the feeling of something missing or left out does he or she complement this questioning.

We have very often received comments from students who find that this part especially of the work creates touching experiences. The combination of listening and concentration on the body can release feelings on a very primitive and deep level.

6. *Relaxation/massage work*

   The psychodynamic movement work can go very deep and very often addresses death/rebirth or death/rebirth-like topics. The students often get very exhausted and need to be taken care of before leaving the room.

This can be worked out in different ways, for example, we often closed the day in the same way as we started, letting the group members lie down on a mattress while the principal therapist addressed different parts of the body – but here with focus on the acceptance of caring feelings (for example, 'feel your shoulder joints – accept whatever you experience there and give it a lot of caring energy').

This part of the work mostly ended with some relaxation music – recorded or improvised. The closing situation can also be formed as massage work in dyads where the principal therapist guides the students through the massage techniques. Neck and head massage can be an especially effective tool for the relaxation of the students after the intensive self-experience work in psychodynamic movement.

When Scheiby and I started this basic training methodology work, we trained students at Aalborg University and students at *Hochschule für Musik und Darstellende Kunst*, Hamburg, through regular training. This meant a one-day session a month for each student group.

Within this time schedule we selected a topic for each one-day seminar and usually let the process develop, giving us ideas for the topic of the following training seminar. This gave the students (as we were told in the feedback) a very homogenous feeling of the process.

Examples of topics we worked on are centring, breathing, strength, sexuality, separation, closeness/distance, the inner child, the inner teenager, the inner adult, femininity/masculinity, grounding, feet, hands, back, face, heart, and so on.

Through all phases of progression of the model we emphasized the importance of working:

- both on an inner and outer movement level, concerning space, direction, intensity and relation;
- on releasing feelings and energy, addressing conflicting life topics for the participants;
- on body awareness – integrating outer and inner sensations with inner experiences;
- on promoting a psychodynamic experience of yourself, your body and your relation to the surroundings.

The model as developed by Metzner and Pedersen

When Scheiby moved to the US in 1990, I continued the training at the post-graduate music therapy course in Hamburg with a student from the first training group there – Susanne Metzner. We continued in the same spirit as already developed but we developed two important changes within the training discipline.

First, Metzner had undertaken courses in yoga and different other styles of movement training and she brought a lot of new ideas for the warming-up section of the work.

Second, the schedule of the courses was changed, so now the students had psychodynamic movement for three successive days every half year, instead of one day a month. This meant that a student group during a three-year training programme would undertake six long block courses in psychodynamic movement.

This inspired Metzner and me to create fixed topics to each course block, and no longer let the continuous process determine the topics. We did this because, first of all, it was difficult to keep a continuous process with half a year between the course blocks. Second, a three-day block course gave us the possibility of building and closing a process within one topic in a student group. Finally, during the years we had experienced which topics were most frequently repeated in the different student group processes.

The six fixed topics for the long block courses were the following:

1. tuning in – individual/group member;
2. centring – chaos/harmony;
3. the inner child – the inner parents;
4. the inner partners – female/male – authority/emphatic;
5. submission/borders – symbiosis/separation;
6. parting – individual/group member.

Gradually we developed a model where Metzner trained the students once a month for three hours in body and movement exercises, in between the long blocks. I think this gave the students optimal conditions for the training, emphasizing training of the improvisational tool – the body – and still having a therapist dyad to take care of the psychodynamic movement blocks and intensive self-experience work every half year.

Psychodynamic movement trained by only one music therapist

As in all programmes, budget problems are part of the reality, and we had to develop a model after some years that could be taught by only one music therapist. This means that Metzner now continues psychodynamic movement work at the postgraduate music therapy training course in Hamburg, while I undertake the psychodynamic movement training with the students on the MA music therapy programme at Aalborg University and with art therapy students in Denmark. Scheiby undertakes psychodynamic movement training with students at New York University and with art therapy students in New York. It is my personal hope that all three of us one day can collect our experiences into an inspiring exercise book on psychodynamic movement as a basic training discipline for music therapy students. I want to continue this chapter by sharing some of my personal ideas developed after having taught psychodynamic movement by myself.

Before I move into this part I want to build a little bridge by bringing some reflections on methods and their transition through generations of music therapists.

Recognition of methods – creators – followers

When I studied in Herdecke, Mary Priestley (with whom I also undertook six individual music therapy sessions and twelve Intertherapy sessions) always said: '*Take from me what you can use and identify with and make it into your own method*'.

I think all methods created by music therapists will be further developed by the therapist who practises the method, and this tells me that it is very important to know the origin of basic ideas of a method at the same time as it is always necessary to realize that any idea one creates of a certain method will be coloured and further developed throughout further generations. Therefore I think that a method should not carry the name of the original creator through the generations.

On the other hand I think it is very easy (in such a creative field as music therapy) to think that you have created everything yourself, thus not paying enough respect to the surviving ideas, their creators, and the history of their development.

This article is one way for me to try to follow the history of an idea – the idea of psychodynamic movement and the way this idea has been transformed through the practitioners using it.

I would like to continue this chapter by bringing some of my own ideas developed after teaching psychodynamic movement on my own, still knowing that my ideas would probably never have been developed if I had not been part of the history, and also knowing how much I am indebted to, first of all, my primary teacher in the method, Mary Priestley, but also my colleagues Scheiby and Metzner and my students.

Psychodynamic movement – prototype exercises developed by the author

I would like to end by describing what I call a few *Prototype exercises* in psychodynamic movement work.

One of the reasons why I have had to develop prototype exercises has been simple need. Often, in the beginning of the training, it has not been possible to ask a student to play the music for the psychodynamic movement section. So I had to create other ways of getting into deep experiences where I could guide and keep the overview at the same time. What I am sharing here has, mostly, been developed through my work experiences with the music therapy students on the MA programme at Aalborg University and, since 2001, with art therapy students at the private art therapy programme at Ulriksholm Castle, Denmark (Engels-holm Castle).

In Aalborg the students have a long block course at the beginning and end of the first semester, when I address topics two and five of the repertory developed by Metzner and myself in Hamburg. They also have a long block course at the beginning and end of the fifth semester, when I address topics three, four and six of the six topics mentioned above. Finally, they have a long block course at the end of the sixth semester when I show them how to integrate the psychodynamic movement techniques into psychodynamic group leading.

In the first semester training (shortly after the students have joined the programme) I still follow the building up of a general frame, as described in the Pedersen and Scheiby model, but, instead of building up to a psychodynamic movement climax, I often build up to the following exercises as the climax following wakening, warming up, energy work and body analysis work.

I have chosen the term *prototype exercises* to describe a few exercises I have created as a base for the training – exercises which give orientation and insight to a lot of further exercises and improvisations within the total frame of psychodynamic movement work. The prototype exercises described here are

not psychodynamic movement in the defined meaning of the term, 'improvised movement to improvised music'. They are more like basic forerunners of this double improvisational work. As mentioned above, forerunners have been developed in forms of one-to-one improvising movement and music, and forerunner exercises have been developed concerning body awareness, body sensation and body communication.

The *first prototype exercise* described here is a forerunner concerning awareness of orientation when being in contact with yourself and the surroundings.

The *second prototype exercise* described here is a forerunner of psychodynamic work on the inner child and the inner parents as it confronts those topics in a safe and fixed body position.

Prototype exercise one: Three sound spaces of communication

I got the original idea for this exercise from my colleague Morten Højgaard at Aalborg University, who often brought the exercise into the training of group music therapy. I have developed it, greatly emphasizing the way in which the exercise is guided. First I will describe the exercise, and then the important way of guiding and of being present as a group leader for the students.

The group divides into pairs. If the group members know each other beforehand they are told to find a partner, whom they can recognize as quite different from themselves. Each pair chooses an A and a B person and finds a place in the room where they have the feeling of not being too close to the other pairs.

All A persons place themselves with a little space between the feet, with loose knees, and they try to find the balance in keeping the body neither too far forwards nor backwards. The shoulders are moved up to the ears so that they fall into a natural position by themselves. They are instructed: 'Close your eyes and prepare yourself to go deep into intrapersonal experiences through body sensations and voice improvisation.'

All B persons observe and listen carefully to the A persons through the total exercise, which will fall into three parts. The B persons can stand, sit or move around to find the best listening position without touching or disturbing the A persons.

While listening, the B persons are expected to try to imagine what it would be like to be the A person inside these three sound spaces, as they listen during

A's improvisation. The A persons improvise with their voices throughout the three parts of the improvisation, which will be guided by the group leader.

The group leader also beats a hand drum as starting and closing signals for all three improvisation parts.

Improvisation part one: The private sound space – private circle around yourself

Instruction: 'In the first part imagine you are recognizing and exploring the space inside your body and going out to a circle just around the body – exploring what you might call your private circle. Imagine the circle as the one where you can hide yourself when you want to be out of contact with others and also the space behind the circle where you can return and regain your energy and inner resourses. Explore this space behind the private circle with your voice and give sound to it. Allow yourself to stay there for some time and be aware of how it feels like to be behind this private circle.'

The improvisation can last from 5 to 12 minutes dependent on the security of the group.

After the sound has faded out it is important for the group leader to comment: 'Keep standing in the same position with your eyes closed and allow yourself to let the sounds of the private room give resonance inside you'.

Improvisation part two: The social sound space – the social circle around yourself

Instruction: 'In the second part of the improvisation imagine you are moving further out to the social space – to the social circle around yourself – where you make yourself open to influence and to be influenced by the other improvisers' sounds. You may get into dialogues or you may not. Most important is that you try to be aware of keeping in contact with the first private space when you move out into the social space. If you feel as if you are losing contact with the private space during the improvisation, stop and try to re-establish the contact with the private space, before you move out into the social space again and make yourself open to influence and to be influenced by others, or to develop ideas together with others.

The improvisation lasts from 5 to 12 minutes.

The group leader comments, 'Keep standing with your eyes closed and allow yourself to let the sounds from this social room give resonance inside you.'

Improvisation part three: The omnipotent sound space – being the soloist

Instruction: 'In the third part of the improvisation allow yourself to move out into your omnipotent space – where you are allowed to fill the entire outer space you are standing in with your special voice sounds. Don't worry about the others – they have exactly the same allowance. Think of yourself as a soloist standing on stage, trying to reach the audience at the back row, very far away. Allow yourself to fill the outer space and find your way to express the power you have inside yourself.

'But – most important – during the improvisation don't lose the contact with the private space. Try to be aware of your expression as coming out of a line from your private space to your omnipotent space. If you feel you are losing contact with your private space allow yourself to stop and to re-establish this contact before you throw yourself into the improvisation again.'

The improvisation lasts from 5 to 12 minutes.

The final instruction may be: 'Now keep standing with closed eyes and allow yourself to let the sounds from the third omnipotent sound space make a resonance inside you. Try also to recognize and inform yourself about the three different sound spaces – the private space, the social space and the omnipotent space, without filling them with voice sounds. Now sit down, A and B in pairs, and talk about the experience in the following form: A tells about her or his experience through all three sound spaces, before B starts to give her or his impressions of being a listener and trying to imagine how it would feel to be the person inside the sound space.'

In this last part of the feedback from B it can be very helpful to have a partner whom A recognizes as very different from her- or himself – it may bring new insight and aspects to the self-picture and self-awareness of A.

After having shared the experiences in pairs there will be a verbal round within the total group where every person has the possibility to share the most important experiences and to get feedback from the group leader.

Reflections on prototype exercise one

As you may have already guessed, people who feel very comfortable improvising in the first, private space often feel very uncomfortable improvising in the third, omnipotent space – and vice versa, as the two examples below demonstrate.

For some students it can be a peak experience to allow themselves to be fully in the third sound space, not having to think about disturbing others. (The topic of being afraid of disturbing others in sound giving is very, very common.)

> An art therapy student, who thought of herself as being totally unmusical, suddenly got in contact with a very authentic, jazzlike voice quality which made her forget all about the others, and gave her a feeling of being on a stage in a big music hall – totally swinging inside the voice expression. As she said, 'If I hadn't had my eyes closed I would never ever have had the courage to let myself just be so seduced by the power of my own voice.'

> A music therapy student once became very scared, noticing that she was not really able to stay in the first sound space – it felt too empty, uncomfortable and scary. She realized during the exercise that she might have something to work on in her individual self-experience work, and she had the courage to admit that, until the present day, she did not really understand why those self-experience elements were part of the training programme.

When working with psychiatric clients I have used my own experiences with this particular exercise to try to inform myself when being in instrumental or voice improvisation dyads.

I have noticed that to communicate most clearly with clients with autism spectrum disorders it is often necessary for me to stay in my private sound space with that deep contact to my body in order to be able to create an alliance with the client.

In improvisation work with schizophrenic patients I have often experienced that sometimes I have to be able to follow their expressions of being in the omnipotent sound space by allowing myself to move out in my omnipotent sound space – but most important without losing contact with my private sound space and my body awareness.

Knowing the sound space and having tried this exercise several times gives me a basic orientation in my way of being in contact with the clients.

The experiences of students with this exercise appears to be of great value when they move into more complex forms where they need to, for example, improvise with voices and move around, or listen to improvised music and move around in a group where the guiding may sound like 'Try to be aware of what is going on in the contact with yourself and the others during the improvisation'.

The experience from the orientation exercise in the three sound spaces can also be transferred to the experience of moving around without using the voice or listening to music, but only having the task of sensing where I am and where I want to be concerning body and energy contact with the other group members.

After having experienced this exercise at the beginning of the first semester the students write down their personal statements on being in the three sound spaces and keep them in a closed file. By the end of their fifth semester the exercise is repeated and the students again write down personal statements before they one by one open the file from the first semester and read both descriptions and the differences for the group and the group leader.

The role of the group leader

As a group leader of this exercise, it is very important that you are centred in the different sound space within yourself when guiding the students through the different improvisation parts. It is also extremely important to be very attentive, with a free-floating consciousness, which allows you to follow each of the improvisers in their exploring work. I expect from myself as a group leader that I am able to give very individual feedback to everyone. Since the core idea of the exercise (at least in the omnipotent space) is to allow the students to re-experience the developmental stage of 'see me – hear me', I, as a group leader, move into the role of the attentive mother for children in that stage – the mother who gives safety in framing and guiding the exploration fields for the students (children), and also afterwards makes it clear to them that you have really heard them and seen them!

Several times the verbal round has been the most important part for students, who, on the one hand, knew that they really did experience something important but who, on the other hand, never thought of themselves as being so important that I – as the group leader – would notice their special experience. Other students could not imagine the group leader being able to overview all improvisers and therefore thought that she probably paid more attention to some of the others.

Of course as a group leader one should not stay in this mother role – but it is a very important element within the work to enter this role and make it clear to yourself as a group leader, and maybe later on also make it clear to the group members.

In my guiding I underline the basic idea of the exercise, namely:

> Most important when you move into the social space (or the omnipotent space) is: don't lose the contact with your private room. If this happens allow yourself to stop and re-establish this contact before you continue.

I want to mention, before continuing with the prototype exercise two, that I use the word guiding both as a word for verbal instructions and for the nonverbal way of following each student group through the process of the exercise.

Prototype exercise two: Sitting in a back-to-back position

I have developed this exercise first with patients and later on with students, within the frame of psychodynamic movement work.

With patients I have used it only in individual work where I was the partner. With students I have used it both in individual work and group work where students work in pairs. When splitting into pairs the students are told to choose a partner with whom they feel safe. Each pair is told to place themselves on a mattress on the floor, sitting back-to-back.

Guiding the 'sitting back-to-back' position

The 'sitting back-to-back' position is very important for the outcome of the exercise:

> Instruction: 'Try to sit very close to one another, so that the lower part of your back is in contact with your partner. Be sure that one person doesn't carry too much of the weight of the other, or vice versa. Place your legs as you feel is most comfortable for you – it may be crossed legs, bowed knees or with legs stretched out. Close your eyes and feel the contact with your partner through your back. Make your breathing deep and quiet and imagine yourself breathing all through your back and into your partner's back. Let go of the lower jaw and allow yourself to feel a lot of space in your throat – let go around the roots of the tongue and prepare yourself to improvise with voice sounds based on your body sensations.'

This sitting position can be the platform for several further instructions leading in the direction of discovering creativity or leading in the direction of getting in contact with different qualities of your inner child and your inner parents' representations.

Improvisation part one

For the first direction – exploring your creativity – the instruction might be: 'In the position you have taken now allow yourself to explore all the sound qualities and dynamics you can make with your voice – don't evaluate the sounds, just try them out and play with the possibilities. Through this exploring phase allow yourself to feel the support through the back of your partner'.

In the final phase of the improvisation the group leader might say: 'Try to find a natural place to stop', or, 'try to find a sound you would like to let be the last one, and fade it out'.

After the improvisation: 'Let the total sound impression resonate in your body'.

Improvisation part two

'Start again with the exploration of your voice sound possibilities and try to find a specific sound that you can identify yourself with just now. Stay with this sound and repeat it again and again through the whole improvisation part.'

In the final phase of this improvisation part: 'Let the sound fade out slowly and let it resonate inside your body after fading out.'

Improvisation part three

'Start again with the same sound and make from it a little melodic form where your starting sound will be the centre tune in the melodic form. Make the melodic form so simple that you can repeat it over and over again and make it your personal melody here and now.'

In the final phase of the improvisation: 'Let the melody fade out and let it resonate inside your body. Try to keep the melody as a small anchor inside yourself.'

When using the 'sitting back-to-back' position for this creativity work, I let all students explore with voice sounds simultaneously. It gives safety to be part of a huge 'sound body' where there is no special attention on the single sound.

The instruction of working through three steps – (chaos–repetition–form) – when related to the 'sitting back-to-back' position is very good as a beginning exercise for anyone who has to start up doing improvisation work with body and voice. Generally, the position gives a sense of safety for most

people. You feel supported in the back (where you can be very tense or feel very insecure) at the same time as having no one facing you, or watching you directly. After this exercise many students have spontaneously said: 'Now I know better what the term 'holding' is about. It is a body experience – like being a child being held by the mother, but still having the freedom to explore without being watched directly'.

For those who feel insecure when improvising freely with their voice, the idea of exploring without evaluation can be very important – it can turn the attention of evaluating each sound into the attention of wandering around any sound produced. Most often I use this 'sitting back-to-back' position for student pairs to work on experiences of different qualities of the inner child and/or the inner parents.

The instruction might sound like:

> Divide the pairs into A and B. A is the improviser, B is the supporter and the listener.
>
> A – try to get in contact with the quality of your inner child – the quality which is most present in your experience here and now. Stay with one quality and allow yourself to go deeply into it and to express all elements of the experience through your voice.
>
> B – listen carefully and give support through the back;
>
> or
>
> B – listen carefully and make a soft voice sound – repeating improvisation as a sounding ground for the improviser.
>
> The group improvisation is finished when the last sound fades out – that means that if anyone is finished before that, do not disturb the other improvisers. You are all still a part of the improvisation until the last sound fades out.

Or the instruction may sound like:

> A – try to get in contact with a caring part of yourself – try to express this quality in voice sounds and be aware of where and how you feel it inside your body.
>
> B is listening and supporting through the back.

Or the instruction might sound:

> A – try first to get in contact with a caring part of yourself – try to express this quality through your voice. Be aware of where and how it feels in your body. When this is clear, go on and get in contact with a part of your inner child, which you know you have difficulties in accepting. Allow this non-accepted part of yourself to be expressed through the voice sounds. Be aware of where and how it feels in your body. When this is clear, allow yourself to let those two different parts of yourself get into a dialogue.
>
> B is listening and supporting through the back.

Reflections on prototype exercise two

As you see, the variation possibilities are rich and you can explore all kinds of qualities concerning the inner child and the inner parents' representations and the dialogue between those parts (aspects of the personality) this way. *It is an intrapersonal art of working through those topics.*

Of course you can also address the topics in a psychodramatic form where you let someone else role play the different parts of yourself and let yourself choose a role or direct the role play the way you want it to take form. There are lots of possibilities.

In this prototype exercise an important issue is that you work on a personal topic with closed eyes and being supported physically without being watched. It is also very important that several students improvise simultaneously on the same topic. This creates a 'sound body' for the single improviser. You can express yourself as a soloist/performer on this 'body', at the same time as not being alone with your sound in the outer space. The students very often get inspired or even provoked to go deeper by listening to someone else shouting or crying or screaming along, or rushing into the most penetrating sounds. Some students may feel very disturbed by the others, but in this kind of work there is no other way than to accept and try to express the disturbance and to find your own sound strength to break through the disturbing elements, or create an inner anchor to let out the disturbances until you are ready to develop a psychodynamic way of handling such disturbances. This problem can be understood as a sounding countertransference problem to deal with.

Finally, the important issue is that the work takes place in your inner experience – in the inner movements, closely connected to body sensations. This gives the students a possibility of recognizing the quality of former experiences using their body as a tool for recognition.

I have used a variety of exercises within this 'sitting back-to-back' position, and I have experienced a lot of students getting in contact with early traumas or deep unknown resourses and being able to express them in the most beautiful voice sounds.

'Individual within a group' working form as a result of the 'sitting back-to-back' exercise

It can often be necessary to let a student/client, who has gone deeply into conflictual experiences, continue in an 'individual within a group' working form, where the student/client can explore the conflict, with all group members as supporters and the group leader as the guiding therapist.

One example could be a student A having the experience of getting in contact with some anger but not really having the courage to express it in the 'sitting back-to-back' position, in the dyad working form. If A feels ready, A can be told to sit in the middle on a mattress with her or his partner B back-to-back with the hands of the group leader on her or his back and stomach to give further support and physical resistance. The group leader will pace the continuous process of expressing the anger and – most important – support A in accepting herself expressing that anger. The rest of the group in this kind of work mostly function as physical supporters to B and as catalysts for A in doubling the sounds of A and encouraging her or him to stay in the process and go through it.

Most often an 'individual within a group' working form has the character of a kind of rebirthing work – for example, giving birth to a forbidden expression – and most often the work ends with A lying or sitting in the middle supported by the whole group, who improvise music with their voices, instructed by the group leader to try to keep in contact with their heart energy during the improvisation, and with the intention of giving healing energy to their fellow student A. It is often a very touching experience and produces the most wonderful spontaneous healing music.

I could go on writing about many, many different exercises, instructions, ideas and experiences from the working area of psychodynamic movement. In this chapter it has been most important for me to outline the history and the transformations of the method and to give a few glimpses of some of my own exercises and working styles.

Conclusion

The main purpose of teaching psychodynamic movement as a continuous basic training method for music therapy students is:

- making the body of the future music therapist sensitive in such a way that he or she can count on personal body sensations and body awareness as a pathway to knowledge of orientation, directions forms intensity and transference/countertransference in the therapist–client relationship in music therapy working areas.
- 'the path to this knowledge might go through work with very basic or primitive feelings and their expressions. In psychodynamic movement it is most important that those feelings and expressions are connected with and recognized through body sensations.

Those two statements will – I think – be survival ideas of psychodynamic movement, the term which was created by Mary Priestley and the method that has undertaken several transformations during successive generations.

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Inge Nygaard Pedersen is the primary founder of the five year full-time MA programme in music therapy at Aalborg University. As assistant professor she was head of the programme from 1982 to 1995. Since 1995 she has been head of the Music Therapy Clinic, a University clinic for treatment and research at Aalborg Psychiatric Hospital. Besides her assistant professorship she has worked clinically with a variety of clients (neurotypical, neurotic, autistic and psychiatric clients) for twenty years. Pedersen has edited four books and written numerous articles for national and international journals.

Mary Priestley has made a substantial contribution to the development of music therapy throughout the world. She formed a crucial bridge between psychoanalytic theory and music therapy by developing the interpretation of unconscious processes as manifested through musical improvisation. Priestley has published two pioneering music therapy books, as well as journal articles and book chapters, and is an internationally renowned teacher.

Colleen Purdon is a music therapist, working with abused children, and a consultant on women's and children's issues. With over twenty years' experience, including clinical and teaching work in Germany and, in Canada, as the executive director of an agency for victims of abuse, Colleen was a founding trustee of the Canadian Music Therapy Trust Fund and a board member of the Canadian Association of Music Therapy.

Benedikte B. Scheiby is a New York based music therapist, teaching at NYU and the Pratt Institute, and Assistant Director of Music at a rehabilitation facility, where she has developed music therapy as psychotherapeutic treatment. She taught psychodynamic movement at Hamburg's Music and Drama Hochschule with Inge Pedersen, and created with her a music therapy MA course at Aalborg University. She has run a private practice for twenty-one years, written a book and numerous articles, and has lectured nationally and internationally. She has also published and performed qualitative music therapy research in a medical context.

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